

DOCUMENT RESUME

ED 177 964

HE 011 826

TITLE Nurse Training Act Amendments of 1979. Hearing before the Subcommittee of Health and the Environment of the Committee on Interstate and Foreign Commerce, House of Representatives, Ninety-Sixth Congress, First Session on H.F. 1143, H.R. 1337, and H.R. 1651 (March 22, 1979).

INSTITUTION Congress of the U. S., Washington, D. C. House Committee on Interstate and Foreign Commerce.

REPORT NO House-Ser-96-6

PUB DATE 22 Mar 79

NOTE 149p.; Some pages may not reproduce well due to light or small type

AVAILABLE FROM Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402

EDRS PRICE MF01 Plus Postage. PC Not Available from EDRS.

DESCRIPTORS Educational Finance; *Educational Legislation; Federal Aid; *Federal Legislation; Financial Support; *Health Occupations Education; Higher Education; Nurses; *Nursing; Public Health; *Student Financial Aid

IDENTIFIERS H R 1143; H R 1337; H R 1651; *Nurse Training Act Amendments 1979; Nursing Education; Position Papers; Public Health Service Act

ABSTRACT

Hearings on the Nurse Training Act Amendments of 1979 are presented. Texts are given of House Resolutions 1143, 1337, 1651, 1820, and 2489 to amend Title VIII of the Public Health Service Act to extend for two fiscal years the program of assistance for nurse training. Statements, testimonies, and letters from witnesses are provided. Among the statements submitted were those of the Honorable Baltasar Corrada, Resident Commissioner of Puerto Rico; Henry Foley, Administrator, Health Resources Administration (DHEW); Mary Lohr, Dean, University of Michigan School of Nursing; and Constance Holleran, American Nurses Association. Material was submitted by the American Nurses Association and the Department of Health, Education and Welfare. Statements and letters submitted for the record include the following sources: the American Hospital Association; the American Association of Colleges of Nursing; the National Student Nurses' Association, Inc.; the American Medical Association and the American Psychiatric Association. (PHR)

* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *

ED177964

NURSE TRAINING ACT AMENDMENTS OF 1979

CE

HEARING BEFORE THE SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT OF THE COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE HOUSE OF REPRESENTATIVES

NINETY-SIXTH CONGRESS

FIRST SESSION

ON

H.R. 1143

(And All Identical Bills)

BILLS TO AMEND TITLE VIII OF THE PUBLIC HEALTH SERVICE ACT TO EXTEND FOR 2 FISCAL YEARS THE PROGRAM OF ASSISTANCE FOR NURSE TRAINING

H.R. 1337

A BILL TO AMEND TITLE VIII OF THE PUBLIC HEALTH SERVICE ACT TO EXTEND FOR 2 FISCAL YEARS THE PROGRAM OF ASSISTANCE FOR NURSE TRAINING

H.R. 1651

A BILL TO AMEND TITLE VIII OF THE PUBLIC HEALTH SERVICE ACT TO EXTEND FOR 2 FISCAL YEARS THE PROGRAM OF ASSISTANCE FOR NURSE TRAINING, AND FOR OTHER PURPOSES

MARCH 22, 1979

Serial No. 96-6



Printed for the use of the
Committee on Interstate and Foreign Commerce

U.S. GOVERNMENT PRINTING OFFICE
WASHINGTON : 1979

45-406 O

U.S. DEPARTMENT OF HEALTH,
EDUCATION & WELFARE
NATIONAL INSTITUTE OF
EDUCATION

THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL NATIONAL INSTITUTE OF EDUCATION POSITION OR POLICY

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE

HARLEY O. STAGGERS, *West Virginia, Chairman*

JOHN D. DINGEL, Michigan
LIONEL VAN DEERLIN, California
JOHN M. MURPHY, New York
DAVID E. SATTERFIELD III, Virginia
BOB ECKHARDT, Texas
RICHARDSON PREYER, North Carolina
JAMES H. SCHEUER, New York
RICHARD L. OTTINGER, New York
HENRY A. WAXMAN, California
TIMOTHY E. WIRTH, Colorado
PHILIP R. SHARP, Indiana
JAMES J. FLORIO, New Jersey
ANTHONY TOBY MOFFET, Connecticut
JIM SANTINI, Nevada
ANDREW MAGUIRE, New Jersey
MARTY RUSSO, Illinois
EDWARD J. MARKEY, Massachusetts
THOMAS A. LUKEN, Ohio
DOUG WALGREN, Pennsylvania
ALBERT GORE, Jr., Tennessee
BARBARA A. MIKULSKI, Maryland
RONALD M. MOTT, Ohio
PHIL GRAMM, Texas
AL SWIFT, Washington
MICKEY LELAND, Texas
RICHARD C. SHELBY, Alabama

SAMUEL L. DEVINE, Ohio
JAMES T. BROYHILL, North Carolina
TIM LEE CARTER, Kentucky
CLARENCE J. BROWN, Ohio
JAMES M. COLLINS, Texas
NORMAN F. LENT, New York
EDWARD R. MADIGAN, Illinois
CARLOS J. MOORHEAD, California
MATTHEW J. RINALDO, New Jersey
DAVE STOCKMAN, Michigan
MARC L. MARKS, Pennsylvania
TOM CORCORAN, Illinois
GARY A. LEE, New York
TOM LOEFFLER, Texas
WILLIAM E. DANNEMEYER, California

W. E. WILLIAMSON, *Chief Clerk and Staff Director*
KENNETH J. PAINTER, *First Assistant Clerk*
GEORGE E. HARDY, Jr., *Professional Staff*
FRANCES LEE DEPEYSTER, *Staff Associate (Minority)*

SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

HENRY A. WAXMAN, *California, Chairman*

DAVID E. SATTERFIELD III, Virginia
RICHARDSON PREYER, North Carolina
ANDREW MAGUIRE, New Jersey
THOMAS A. LUKEN, Ohio
DOUG WALGREN, Pennsylvania
BARBARA A. MIKULSKI, Maryland
PHIL GRAMM, Texas
MICKEY LELAND, Texas
RICHARD C. SHELBY, Alabama
JOHN M. MURPHY, New York
HARLEY O. STAGGERS, West Virginia
(*Ex Officio*)

TIM LEE CARTER, Kentucky
EDWARD R. MADIGAN, Illinois
DAVE STOCKMAN, Michigan
WILLIAM E. DANNEMEYER, California
GARY A. LEE, New York
SAMUEL L. DEVINE, Ohio
(*Ex Officio*)

ELLIOT A. SEGAL, *Staff Director*

(II)

CONTENTS

Text of—	Page
H.R. 1143	3
H.R. 1337	13
H.R. 1651	17
H.R. 1820	3
H.R. 2489	3
Statement of—	
Corrada, Hon. Baltasar, Resident Commissioner of Puerto Rico	27
Foley, Henry, Ph. D., Administrator, Health Resources Administration, Public Health Service, Department of Health, Education, and Welfare ..	28
Hauer, Rose M., R.N., M.A., on behalf of National League for Nursing	53, 66
Hines, Ralph H., M.D., provost and executive vice president, Meharry Medical Center, Nashville (Tenn.), and on behalf of Xavier University of New Orleans and School of Veterinary Medicine, Tuskegee Institute (Ala.)	117
Holleran, Constance, American Nurses Association	53, 75
Kelly, Joyce, C.R.N.A., on behalf of American Association of Anesthetists	105
Lohr, Mary, Ed. D., dean, University of Michigan School of Nursing	53
Whiteside, Daniel F., D.D.S., Director, Bureau of Manpower, Public Health Service, Department of Health, Education, and Welfare	28
Additional materials submitted for the record by—	
American Nurses' Association, Inc., attachment to Ms. Holleran's prepared statement, response to HEW report	89
ANA critique to chapter 6 of second report to Congress	98
Health, Education, and Welfare:	
Foley, Henry, attachments to prepared statement:	
Admissions to nursing schools have increased	32
Number of nurses graduating with advanced training is higher, the	32
On balance, by 1985 the aggregate supply of nurses will fall within the range of aggregate demand	33
Supply projections	50
Statements submitted for the record by—	
American Hospital Association	136
American Association of Colleges of Nursing	126
National Student Nurses' Association, Inc.	131
Letters submitted for the record by—	
American Medical Association, James H. Sammons, M.D., executive vice president	145
American Psychiatric Association, Jules H. Masserman, M.D., president ...	142

NURSE TRAINING ACT AMENDMENTS OF 1979

THURSDAY, MARCH 22, 1979

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10 a.m., in room 2218, Rayburn House Office Building, Hon. Henry A. Waxman, chairman, presiding.

Mr. WAXMAN. The meeting will please come to order.

Today we begin hearings on the Nurse Training Act, a program that has been operating for 15 years. During that time significant changes have occurred in the nursing profession, many as a result of the Nurse Training Act.

Before the act was passed, 23 percent of all nursing positions were unfilled; 10 percent of skilled nursing homes had no nurses at all.

In the last 15 years, many changes have occurred in nursing institutions; the rate of increase in nursing enrollment has doubled; the number of nurses per 100,000 population jumped from 279 in 1966 to 382 10 years later.

There was a 500 percent increase in minority enrollment from 1965 to 1971. Schools were constructed with funds from this act. Curricula were improved with many new programs added such as nurse practitioner training, training researchers, administrators and supervisory nurses.

Hundreds of thousands of students were supported in their training, many of whom might not have been able to attend without this program.

Now we are faced with a policy question whether or not the Nurse Training Act has achieved its goal and should be phased out. Some studies indicate a distribution problem and not an aggregate shortage. Other studies indicate a continuing aggregate shortage as well as an unequal distribution of nurses.

An important provision we are considering today is for the National Academy of Sciences to study nurse manpower needs and report to the Congress.

While I have not seen conclusive evidence on one side or the other with respect to the questions of a shortage of nurses, some items trouble me.

Within the past year, approximately 50 articles and editorials have appeared in California newspapers describing nursing shortages. In 1979, Los Angeles County, my home county, had 500 vacancies for nurses. A little further north in Alameda, a newspaper

(1)

reported that Highland Hospital temporarily closed an emergency trauma center due to a nursing shortage.

Yet, it has been proposed to eliminate most of the programs contained in the Nurse Training Act. It seems to me that we need more information before taking such a precipitous step.

I believe a more prudent course would be to continue this program for 1 year at which time the Health Professions Education Assistance Act expires. By that time, the study of the nursing profession will be available and Congress should be able to consider nursing profession needs within the larger context of the entire health manpower needs of the country.

Without objection the text of H.R. 1143, H.R. 1820, H.R. 2489, H.R. 1337, and H.R. 1651 will be placed at this point in the record.

[Testimony resumes on p. 27.]

[The text of H.R. 1143, H.R. 1820, H.R. 2489, H.R. 1337, and H.R. 1651 follow:]

[H.R. 1143, Introduced by Mr. STAGGERS on January 18, 1979

Cosponsored on March 8, 1979, by:

Mr. WAXMAN, Mr. OTTINGER, Mr. WALGREN, Mr. GRAMM, Mr. YATES, Mr. ANDREWS (ND), Mr. LONG (MD), Mr. McDADE, Mr. DUNCAN (TN), Mr. WOLFF, Mr. MONTGOMERY, Mr. ANDERSON (CA), Mr. GINN, Mrs. HOLT, Mr. JOHNSON (CO), Mr. TRAXLER, Mr. AMBRO, Mr. BEARD (RI), Mr. BEDELL, Mr. D'AMOURS, Mr. JEFFORDS, Mr. OBERSTAR, Mr. RICHMOND, Mr. FOWLER, Mr. LEACH, (IA), Mr. YOUNG (MO), Mr. WEISS, Mr. GREEN, Mr. LEACH, (LA), Mr. TAUKE; and

H.R. 1820, introduced by Mr. SATTERFIELD on February 1, 1979;

H.R. 2489, introduced by Mrs. HECKLER on February 28, 1979, are identical as follows:]

96TH CONGRESS
1ST SESSION

H.R. 1143

To amend title VIII of the Public Health Service Act to extend for two fiscal years the program of assistance for nurse training.

IN THE HOUSE OF REPRESENTATIVES

JANUARY 18, 1979

Mr. STAGGERS introduced the following bill; which was referred to the Committee on Interstate and Foreign Commerce

A BILL

To amend title VIII of the Public Health Service Act to extend for two fiscal years the program of assistance for nurse training.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 TITLE I—NURSE TRAINING

4 SECTION 101. (a) This Act may be cited as the "Nurse
5 Training Amendments of 1979".

6 (b) Whenever in this Act (other than section 204) an
7 amendment or repeal is expressed in terms of an amendment
8 to, or repeal of, a section or other provision, the reference

1 shall be considered to be made to a section or other provision
2 of the Public Health Service Act.

3 SEC. 102. Section 801 (relating to authorizations for
4 construction grants) is amended by inserting after "for fiscal
5 year 1978" the following: "and for each of the next two
6 fiscal years".

7 SEC. 103. (a) Subsections (a) and (b) of section 805 (re-
8 lating to loan guarantees and interest subsidies) are each
9 amended by striking out "1978" and inserting in lieu thereof
10 "1980".

11 (b) Subsection (e) of such section is amended by insert-
12 ing after "in fiscal year 1978" the following: "and in each of
13 the next two fiscal years".

14 SEC. 104. Subsection (f) of section 810 (relating to capi-
15 tation grants) is amended by inserting after "fiscal year
16 1978" the following: "and for each of the next two fiscal
17 years".

18 SEC. 105. The first sentence of subsection (d) of section
19 820 (relating to special project grants and contracts) is
20 amended by striking out "and" after "1977," and by insert-
21 ing before the period the following: ", \$20,000,000 for the
22 fiscal year ending September 30, 1979, and \$20,000,000 for
23 the fiscal year ending September 30, 1980".

24 SEC. 106. Subsection (b) of section 821 (relating to ad-
25 vanced nurse training programs) is amended by inserting

1 after "for fiscal year 1978" the following: "and for each of
2 the next two fiscal years".

3 SEC. 107. Subsection (e) of section 822 (relating to
4 nurse practitioner programs) is amended by striking out "for
5 fiscal year 1978" and inserting in lieu thereof "for the fiscal
6 year ending September 30, 1978, and for each of the next
7 two fiscal years".

8 SEC. 108. Subsection (b) of section 830 (relating to
9 traineeships) is amended by inserting before the period "and
10 for each of the next two fiscal years".

11 SEC. 109. (a) Subsection (b)(4) of section 835 (relating
12 to loan agreements) is amended by striking out "1978" and
13 inserting in lieu thereof "1980".

14 (b) Section 837 (relating to authorizations for student
15 loan funds) is amended (1) by inserting before the period in
16 the first sentence "and for each of the next two fiscal years",
17 (2) by striking out "fiscal year 1979" and inserting in lieu
18 thereof "the fiscal year ending September 30, 1981", and (3)
19 by striking out "October 1, 1978" and inserting in lieu there-
20 of "October 1, 1980".

21 (c)(1) Subsection (a) of section 839 (relating to distribu-
22 tion of assets) is amended by striking out "September 30,
23 1980, and not later than September 30, 1977" and inserting
24 in lieu thereof "September 30, 1981, and not later than De-
25 cember 30, 1983".

1 (2) Paragraph (1) of such subsection is amended by
2 striking out "1980" and inserting in lieu thereof "1983".

3 (3) Subsection (b) of such section is amended by striking
4 out "1980" each place it occurs and inserting in lieu thereof
5 "1983".

6 SEC. 110. (a) Subsection (b) of section 845 (relating to
7 scholarship grants) is amended (1) by striking out "next two
8 fiscal years" in the first sentence and inserting in lieu thereof
9 "next four fiscal years", (2) by striking out "1979" and in-
10 serting in lieu thereof "1981", and (3) by striking out
11 "1978" and inserting in lieu thereof "1980".

12 (b) Subsection (c)(1) of such section is amended (1) by
13 striking out "next two fiscal years" in subparagraph (A) and
14 inserting in lieu thereof "next four fiscal years", (2) by strik-
15 ing out "1978" in subparagraph (B) and inserting in lieu
16 thereof "1980", and (3) by striking out "1979" in such sub-
17 paragraph and inserting in lieu thereof "1981".

18 SEC. 111. Subpart I of part B of title VIII (relating to
19 traineeships) is amended by adding after section 830 the fol-
20 lowing new section:

21 "TRAINEESHIPS FOR TRAINING OF NURSE ANESTHETISTS

22 "SEC. 831. (a)(1) The Secretary may make grants to
23 public or private nonprofit institutions to cover the costs of
24 traineeships for the training, in programs which meet such
25 requirements as the Secretary shall by regulation prescribe

1 and which are accredited by an entity or entities designated
2 by the Commissioner of Education, of licensed, registered
3 nurses to be nurse anesthetists.

4 “(2) Payments to institutions under this subsection may
5 be made in advance or by way of reimbursement, and at such
6 intervals and on such conditions, as the Secretary finds nec-
7 essary. Such payments may be used only for traineeships and
8 shall be limited to such amounts as the Secretary finds neces-
9 sary to cover the costs of tuition and fees, and a stipend and
10 allowances (including travel and subsistence expenses) for the
11 trainees.

12 “(b) For the purpose of making grants under subsection
13 (a), there are authorized to be appropriated \$2,000,000 for
14 the fiscal year ending September 30, 1979, and \$3,000,000
15 for the fiscal year ending September 30, 1980.”.

16 SEC. 112. Section 836(b)(3) (relating to student loans) is
17 amended (1) by inserting after “(3)” the following: “in the
18 case of a student who received such a loan before the date of
19 enactment of the Nurse Training Amendments of 1979,”,
20 and (2) by striking out “any such loan” and inserting in lieu
21 thereof “any such loan made before such date”.

22 SEC. 113. (a) The Secretary of Health, Education, and
23 Welfare (hereinafter in this section referred to as the “Secre-
24 tary”) shall arrange, in accordance with subsection (b), for
25 the conduct of a study to determine the need to continue a

1 specific program of Federal financial support for nursing edu-
2 cation, taking into account--

3 (1) the need for nurses under the present health
4 care delivery system and under that system as it may
5 be changed by the enactment of legislation for national
6 health insurance,

7 (2) the cost of nursing education, and

8 (3) the availability of other sources of support for
9 nursing education, including support under general pro-
10 grams of Federal financial support for postsecondary
11 education, under State and other public programs, and
12 from private sources.

13 (b)(1) The Secretary shall first request the National
14 Academy of Sciences (hereinafter in this section referred to
15 as the "Academy"), acting through the Institute of Medicine,
16 to conduct the study, required by subsection (a), under an
17 arrangement whereby the actual expenses incurred by the
18 Academy directly related to the conduct of such study will be
19 paid by the Secretary. If the Academy agrees to such re-
20 quest, the Secretary shall enter into such an agreement with
21 the Academy.

22 (2) If the Academy declines the Secretary's request to
23 conduct such study under such an arrangement, then the
24 Secretary shall enter into a similar arrangement with another

1 appropriate public or nonprofit private entity to conduct such
2 study.

3 (3) Upon completion of the study, the entity conducting
4 the study shall report the results of it to the Secretary and
5 shall include in such report any recommendations for legisla-
6 tion which the entity determines are appropriate.

7 (4) Any arrangement entered into under paragraph (1)
8 or (2) of this subsection for the conduct of a study shall re-
9 quire that such study be completed and reports thereon be
10 submitted within such period as the Secretary may require to
11 meet the requirements of subsection (c).

12 (c) Not later than October 1, 1979, the Secretary shall
13 report to the Committee on Human Resources of the Senate
14 and the Committee on Interstate and Foreign Commerce of
15 the House of Representatives the results of the study con-
16 ducted pursuant to subsection (a) together with such recom-
17 mendations for legislation as the Secretary determines are
18 appropriate.

19 (d) The authority of the Secretary to enter into any con-
20 tract for the conduct of the study under this section shall be
21 effective (1) only on and after October 1, 1978, and (2) for
22 any fiscal year only to such extent or in such amounts as are
23 provided in advance in appropriation Acts.

1 **TITLE II—OTHER HEALTH PROFESSIONS**
2 **PROGRAMS**

3 **SEC. 201.** Section 729(a) (relating to limits on Federal
4 loan insurance and insured loans) is amended—

5 (1) by inserting before the period in the first sen-
6 tence a comma and the following: "except that in the
7 case of loans to students in schools of medicine, oste-
8 opathy, and dentistry, the Secretary may increase the
9 total of such loans which may be covered by Federal
10 loan insurance to \$15,000 if he determines that the
11 costs of education at such schools requires such in-
12 crease"; and

13 (2) by inserting before the period in the second
14 sentence a comma and the following: "except that the
15 Secretary may increase such amount for borrowers
16 who are or were students in schools of medicine, oste-
17 opathy, and dentistry to \$60,000 if he determines that
18 the costs of education at such schools requires such in-
19 crease".

20 **SEC. 202.** Section 752(b)(5)(A) (relating to service re-
21 quirements for National Health Service Corps scholarships)
22 is amended by striking out "(not to exceed three years)" and
23 inserting in lieu thereof "(not to exceed three years or such
24 greater period as the Secretary, consistent with the needs of
25 the Corps, may authorize)".

1 SEC. 203. Section 781(c) (relating to requirements for
2 participation of schools in area health education center pro-
3 grams) is amended by adding after and below paragraph (4)
4 the following:

5 "The requirement of paragraph (3) shall not apply to a medi-
6 cal or osteopathic school participating in an area health edu-
7 cation center program if another such school participating in
8 the same program meets the requirement of that
9 paragraph."

10 SEC. 204. Section 802(a) of the Health Professions
11 Educational Assistance Act of 1976 (relating to transitional
12 provisions on area health education centers) is amended—

13 (1) by striking out "for the next fiscal year" and
14 inserting in lieu thereof "for the next three fiscal
15 years";

16 (2) by striking out "no payment shall be made to
17 an entity under such a contract" and inserting in lieu
18 thereof "no payment under such a contract shall be
19 made to an entity which had not first entered into such
20 a contract before October 12, 1976, (1)"; and

21 (3) by inserting before the period at the end there-
22 of the following: ", or (2) for any fiscal year beginning
23 after September 30, 1979".

12

10

1 SEC. 205. Subparagraph (B) of section 788(c)(2) is
2 amended by striking out "\$5,000,000" and inserting in lieu
3 thereof "\$10,000,000".

16

96TH CONGRESS
1ST SESSION

H. R. 1337

To amend title VIII of the Public Health Service Act to extend for two fiscal years the program of assistance for nurse training.

IN THE HOUSE OF REPRESENTATIVES

JANUARY 24, 1979

Mr. CONTE introduced the following bill; which was referred to the Committee on Interstate and Foreign Commerce

A BILL

To amend title VIII of the Public Health Service Act to extend for two fiscal years the program of assistance for nurse training.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 SHORT TITLE

4 SECTION 1. (a) This Act may be cited as the "Nurse
5 Training Amendments of 1979".

6 (b) Whenever in this Act an amendment or repeal is
7 expressed in terms of an amendment to, or repeal of, a sec-
8 tion or other provision, the reference shall be considered to

1 be made to a section or other provision of the Public Health
2 Service Act.

3 SEC. 2. Section 801 (relating to authorizations for con-
4 struction grants) is amended by inserting after "for fiscal
5 year 1978" the following: "and for each of the next two
6 fiscal years".

7 SEC. 3. (a) Subsections (a) and (b) of section 805 (relat-
8 ing to loan guarantees and interest subsidies) are each
9 amended by striking out "1978" and inserting in lieu thereof
10 "1980".

11 (b) Subsection (e) of such section is amended by insert-
12 ing after "in fiscal year 1978" the following: "and in each of
13 the next two fiscal years".

14 SEC. 4. Subsection (f) of section 810 (relating to capita-
15 tion grants) is amended by inserting after "fiscal year 1978"
16 the following: "and for each of the next two fiscal years".

17 SEC. 5. The first sentence of subsection (d) of section
18 820 (relating to special project grants and contracts) is
19 amended by striking out "and" after "1977", and by insert-
20 ing before the period the following: ", \$20,000,000 for the
21 fiscal year ending September 30, 1979, and \$20,000,000 for
22 the fiscal year ending September 30, 1980".

23 SEC. 6. Subsection (b) of section 821 (relating to ad-
24 vanced nurse training programs) is amended by inserting

1 after "for fiscal year 1978" the following: "and for each of
2 the next two fiscal years".

3 SEC. 7. Subsection (e) of section 822 (relating to nurse
4 practitioner programs) is amended by striking out "for fiscal
5 year 1978" and inserting in lieu thereof "each for the fiscal
6 year ending September 30, 1978, and for the next two fiscal
7 years".

8 SEC. 8. Subsection (b) of section 830 (relating to train-
9 eeships) is amended by inserting before the period "and for
10 each of the next two fiscal years".

11 SEC. 9. (a) Subsection (b)(4) of section 835 (relating to
12 loan agreements) is amended by striking out "1978" and in-
13 serting in lieu thereof "1980".

14 (b) Section 837 (relating to authorizations for student
15 loan funds) is amended (1) by inserting before the period in
16 the first sentence "and for each of the two fiscal years", (2)
17 by striking out "fiscal year 1979" and inserting in lieu there-
18 of "the fiscal year ending September 30, 1981", and (3) by
19 striking out "October 1, 1978" and inserting in lieu thereof
20 "October 1, 1980".

21 (c) (1) Subsection (a) of section 839 (relating to distribu-
22 tion of assets) is amended by striking out "September 30,
23 1980, and not later than September 30, 1977" and inserting
24 in lieu thereof "September 30, 1981 and not later than De-
25 cember 30, 1983".

1 (2) Paragraph (1) of such subsection is amended by
2 striking out "1980" and inserting in lieu thereof "1983".

3 (3) Subsection (b) of such section is amended by striking
4 out "1980" each place it occurs and inserting in lieu thereof
5 "1983".

6 SEC. 10. (a) Subsection (b) of section 845 (relating to
7 scholarship grants) is amended (1) by striking out "next two
8 fiscal years" in the first sentence and inserting in lieu thereof
9 "next four fiscal years", (2) by striking out "1979" and in-
10 serting in lieu thereof "1981", and (3) by striking out
11 "1978" and inserting in lieu thereof "1980".

12 (b) Subsection (c)(1) of such section is amended (1) by
13 striking out "next two fiscal years" in subparagraph (A) and
14 inserting in lieu thereof "next four fiscal years", (2) by strik-
15 ing out "1978" in subparagraph (B) and inserting in lieu
16 thereof "1980", and (3) by striking out "1979" in such sub-
17 paragraph and inserting in lieu thereof "1981".

18 SEC. 11. Subsection (e)(2)(B) of section 788 is amended
19 by (1) striking out "\$5,000,000" and inserting in lieu thereof
20 "\$10,000,000" and (2) inserting "for the fiscal years ending
21 September 30, 1978, and September 30, 1979." after "sub-
22 section (b)".

96TH CONGRESS
1ST SESSION

H. R. 1651

Introduced by Mr. Carter on January 31, 1979
Cosponsored on February 26, 1979, by:
Mr. Pursell, Mr. Pritchard, Mr. Lee, Mr. Findley

A BILL

To amend title VIII of the Public Health Service Act to extend for two fiscal years the program of assistance for nurse training, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 TITLE I—NURSE TRAINING

4 SEC. 101. (a) This Act may be cited as the "Nurse
5 Training Amendments of 1979".

6 (b) Whenever in this Act (other than section 204) an
7 amendment or repeal is expressed in terms of an amendment
8 to, or repeal of, a section or other provision, the reference

1 shall be considered to be made to a section or other provision
2 of the Public Health Service Act.

3 SEC. 102. Section 801 (relating to authorizations for
4 construction grants) is amended (1) by striking out "and"
5 after "1977," and (2) by inserting before the period a
6 comma and the following: "\$20,000,000 for the fiscal year
7 ending September 30, 1980, and \$20,000,000 for the fiscal
8 year ending September 30, 1981".

9 SEC. 103. (a) Subsections (a) and (b) of section 805 (re-
10 lating to loan guarantees and interest subsidies) are each
11 amended by striking out "1978" and inserting in lieu thereof
12 "1981".

13 (b) The second sentence of subsection (e) of such section
14 is amended by striking out "and" after "1977," and (2) by
15 inserting before the period a comma and the following:
16 "\$1,000,000 in the fiscal year ending September 30, 1980,
17 and \$1,000,000 in the fiscal year ending September 30,
18 1981".

19 SEC. 104. Subsection (f) of section 810 (relating to capi-
20 tation grants) is amended (1) by striking out "and" after
21 "1977," and (2) by inserting after "1978," the following:
22 "\$45,000,000 for the fiscal year ending September 30, 1980,
23 and \$45,000,000 for the fiscal year ending September 30,
24 1981".

1 SEC. 105. The first sentence of subsection (d) of section
2 820 (relating to special project grants and contracts) is
3 amended by striking out "and" after "1977," and by insert-
4 ing before the period the following: ", \$20,000,000 for the
5 fiscal year ending September 30, 1980, and \$20,000,000 for
6 the fiscal year ending September 30, 1981".

7 SEC. 106. Subsection (b) of section 821 (relating to ad-
8 vanced nurse training programs) is amended (1) by striking
9 out "and" after "1977," and (2) by inserting before the
10 period a comma and the following: "\$21,000,000 for the
11 fiscal year ending September 30, 1980, and \$21,000,000 for
12 the fiscal year ending September 30, 1981".

13 SEC. 107. Subsection (e) of section 822 (relating to
14 nurse practitioner programs) is amended (1) by striking out
15 "and" after "1977," and (2) by inserting before the period a
16 comma and the following: "\$20,000,000 for the fiscal year
17 ending September 30, 1980, and \$20,000,000 for the fiscal
18 year ending September 30, 1981".

19 SEC. 108. Subsection (b) of section 830 (relating to
20 traineeships) is amended (1) by striking out "and" after
21 "1977," and (2) by inserting before the period a comma and
22 the following: "\$23,000,000 for the fiscal year ending Sep-
23 tember 30, 1980, and \$23,000,000 for the fiscal year ending
24 September 30, 1981".

1 SEC. 109. (a) Subsection (b)(4) of section 835 (relating
2 to loan agreements) is amended by striking out "1978" and
3 inserting in lieu thereof "1981".

4 (b)(1) The first sentence of section 837 (relating to au-
5 thorizations for student loan funds) is amended (A) by striking
6 out "and" after "1977," and (B) by inserting before the
7 period a comma and the following: "\$30,000,000 for the
8 fiscal year ending September 30, 1980, and \$30,000,000 for
9 the fiscal year ending September 30, 1981".

10 (2) The second sentence of such section is amended (A)
11 by striking out "fiscal year 1979" and inserting in lieu there-
12 of "the fiscal year ending September 30, 1982", and (B) by
13 striking out "October 1, 1978" and inserting in lieu thereof
14 "October 1, 1981".

15 (c)(1) Subsection (a) of section 839 (relating to distribu-
16 tion of assets) is amended by striking out "September 30,
17 1980, and not later than September 30, 1977" and inserting
18 in lieu thereof "September 30, 1981, and not later than
19 December 30, 1983".

20 (2) Paragraph (1) of such subsection is amended by
21 striking out "1980" and inserting in lieu thereof "1983".

22 (3) Subsection (b) of such section is amended by striking
23 out "1980" each place it occurs and inserting in lieu thereof
24 "1983".

1 SEC. 110. (a) Subsection (b) of section 845 (relating to
2 scholarship grants) is amended (1) by striking out "next two
3 fiscal years" in the first sentence and inserting in lieu thereof
4 "next five fiscal years", (2) by striking out "1979" and in-
5 serting in lieu thereof "1982", and (3) by striking out
6 "1978" and inserting in lieu thereof "1981".

7 (b) Subsection (c)(1) of such section is amended (1) by
8 striking out "next two fiscal years" in subparagraph (A) and
9 inserting in lieu thereof "next five fiscal years", (2) by strik-
10 ing out "1978" in subparagraph (B) and inserting in lieu
11 thereof "1981", and (3) by striking out "1979" in such sub-
12 paragraph and inserting in lieu thereof "1982".

13 SEC. 111. Subpart I of part B of title VIII (relating to
14 traineeships) is amended by adding after section 830 the fol-
15 lowing new section:

16 "TRAINEESHIPS FOR TRAINING OF NURSE ANESTHETISTS

17 "SEC. 831. (a)(1) The Secretary may make grants to
18 public or private nonprofit institutions to cover the costs of
19 traineeships for the training, in programs which meet such
20 requirements as the Secretary shall by regulation prescribe
21 and which are accredited by an entity or entities designated
22 by the Commissioner of Education, of licensed, registered
23 nurses to be nurse anesthetists.

24 "(2) Payments to institutions under this subsection may
25 be made in advance or by way of reimbursement, and at such

1 intervals and on such conditions, as the Secretary finds nec-
2 essary. Such payments may be used only for traineeships and
3 shall be limited to such amounts as the Secretary finds neces-
4 sary to cover the costs of tuition and fees, and a stipend and
5 allowances (including travel and subsistence expenses) for the
6 trainees.

7 “(b) For the purpose of making grants under subsection
8 (a), there are authorized to be appropriated \$2,000,000 for
9 the fiscal year ending September 30, 1980, and \$2,000,000
10 for the fiscal year ending September 30, 1981.”.

11 SEC. 112. Section 836(b)(3) (relating to student loans) is
12 amended (1) by inserting after “(3)” the following: “in the
13 case of a student who received such a loan before the date of
14 enactment of the Nurse Training Amendments of 1979,”,
15 and (2) by striking out “any such loan” and inserting in lieu
16 thereof “any such loan made before such date”.

17 SEC. 113. (a) The Secretary of Health, Education, and
18 Welfare (hereinafter in this section referred to as the “Secre-
19 tary”) shall arrange, in accordance with subsection (b), for
20 the conduct of a study to determine the need to continue a
21 specific program of Federal financial support for nursing edu-
22 cation, taking into account—

23 (1) the need for nurses under the present health
24 care delivery system and under that system as it may

1 be changed by the enactment of legislation for national
2 health insurance,

3 (2) the cost of nursing education, and

4 (3) the availability of other sources of support for
5 nursing education, including support under general pro-
6 grams of Federal financial support for postsecondary
7 education, under State and other public programs, and
8 from private sources.

9 (b)(1) The Secretary shall first request the National
10 Academy of Sciences (hereinafter in this section referred to
11 as the "Academy"), acting through the Institute of Medicine,
12 to conduct the study, required by subsection (a), under an
13 arrangement whereby the actual expenses incurred by the
14 Academy directly related to the conduct of such study will be
15 paid by the Secretary. If the Academy agrees to such re-
16 quest, the Secretary shall enter into such an agreement with
17 the Academy.

18 (2) If the Academy declines the Secretary's request to
19 conduct such study under such an arrangement, then the
20 Secretary shall enter into a similar arrangement with another
21 appropriate public or nonprofit private entity to conduct such
22 study.

23 (3) Upon completion of the study, the entity conducting
24 the study shall report the results of it to the Secretary and

1 shall include in such report any recommendations for legisla-
2 tion which the entity determines are appropriate.

3 (4) Any arrangement entered into under paragraph (1)
4 or (2) of this subsection for the conduct of a study shall re-
5 quire that such study be completed and reports thereon be
6 submitted within such period as the Secretary may require to
7 meet the requirements of subsection (c).

8 (c) Not later than October 1, 1980, the Secretary shall
9 report to the Committee on Human Resources of the Senate
10 and the Committee on Interstate and Foreign Commerce of
11 the House of Representatives the results of the study con-
12 ducted pursuant to subsection (a) together with such recom-
13 mendations for legislation as the Secretary determines are
14 appropriate.

15 (d) The authority of the Secretary to enter into any con-
16 tract for the conduct of the study under this section shall be
17 effective (1) only on and after October 1, 1979, and (2) for
18 any fiscal year only to such extent or in such amounts as are
19 provided in advance in appropriation Acts.

20 TITLE II—OTHER HEALTH PROFESSIONS
21 PROGRAMS

22 SEC. 201. Section 729(a) (relating to limits on Federal
23 loan insurance and insured loans) is amended—

24 (1) by inserting before the period in the first sen-
25 tence a comma and the following: "except that in the

1 case of loans to students in schools of medicine, oste-
2 opathy, and dentistry, the Secretary may increase the
3 total of such loans which may be covered by Federal
4 loan insurance to \$15,000 if he determines that the
5 costs of education at such schools requires such in-
6 crease"; and

7 (2) by inserting before the period in the second
8 sentence a comma and the following: "except that the
9 Secretary may increase such amount for borrowers
10 who are or were students in schools of medicine, oste-
11 opathy, and dentistry to \$60,000 if he determines that
12 the costs of education at such schools requires such
13 increase".

14 SEC. 202. Section 752(b)(5)(A) (relating to service re-
15 quirements for National Health Service Corps scholarships)
16 is amended by striking out "(not to exceed three years)" and
17 inserting in lieu thereof "(not to exceed three years or such
18 greater period as the Secretary, consistent with the needs of
19 the Corps, may authorize)".

20 SEC. 203. Section 781(c) (relating to requirements for
21 participation of schools in area health education center pro-
22 grams) is amended by adding after and below paragraph (4)
23 the following:

24 "The requirement of paragraph (3) shall not apply to a medi-
25 cal or osteopathic school participating in an area health edu-

1 cation center program if another such school participating in
2 the same program meets the requirement of that para-
3 graph.”.

4 SEC. 204. The first sentence of section 802(a) of the
5 Health Professions Educational Assistance Act of 1976 (re-
6 lating to transitional provisions for projects for area health
7 education centers) is amended—

8 (1) by striking out “for the next fiscal year” and
9 inserting in lieu thereof “for the next three fiscal
10 years”;

11 (2) by striking out “no payment shall be made to
12 an entity under such a contract” and inserting in lieu
13 thereof “no payment under such a contract shall be
14 made to an entity which had not first entered into such
15 a contract before October 12, 1976, (1)”; and

16 (3) by inserting before the period at the end there-
17 of the following: “, or (2) for any fiscal year beginning
18 after September 30, 1979”.

Mr. WAXMAN. Dr. Carter?

Mr. CARTER. Thank you, Mr. Chairman.

As you know, in the past few weeks, there has been considerable debate in the House and Senate about the proper role of the Federal Government in supporting the education of health professionals.

Today we will have an opportunity to examine these issues as they relate to nurse training legislation. My own view is that continued Federal support is necessary and I have introduced legislation to continue such support over the next 2 years.

From my own experience as a physician in rural Kentucky, I have never found there to be a surplus of nurses. I have never found that.

In your own city of Los Angeles which you mentioned, my niece who happens to be a graduate of Vanderbilt and a nurse, received employment immediately after her arrival there, which shows that there is a lack of nursing personnel even in a large city.

I can testify to the fact there is a significant maldistribution of nurses throughout the country, and particularly in rural areas. I share the concern of the administration and the Congress about the need to moderate Federal spending and I will agree with it where it is necessary but certainly I think such reductions should be selective.

We should examine the impact of any reductions in funding very carefully before changing our policies.

This hearing offers us the opportunity to do just that. I look forward, Mr. Chairman, to hearing from our distinguished witnesses today.

Mr. WAXMAN. Thank you, Dr. Carter.

Without objection, the statement of Hon. Baltasar Corrada, Resident Commissioner of Puerto Rico will be printed at this point in the record.

STATEMENT OF HON. BALTASAR CORRADA, RESIDENT COMMISSIONER OF PUERTO RICO

Mr. CORRADA. Mr. Chairman, I respectfully urge the prompt enactment of H.R. 1143 to extend for 2 fiscal years the program of Federal assistance for nurse training.

So far, the rescission of funds recommended by the President and approved by both the House and the Senate has cut back in approximately 20 percent the direct Federal financial aid to nursing schools in Puerto Rico. This aid includes such items as caption grants, student loans, and loan payments.

Our Island, and many densely populated areas throughout the Nation are in constant need of highly qualified professionals in the health field. These professionals would help ameliorate the grave and increasingly greater health problems that such areas face.

We have nine accredited nursing schools throughout the Island which graduate numerous professionals in the nursing field each year. All of these programs receive direct financial help from the Federal Government. For example, the School of Nursing of the University of Puerto Rico Medical School receives aid to subsidize scholarships for graduate and undergraduate programs, student

loans for graduate and undergraduate studies, training and capitation grants.

H.R. 1143 should be approved to guarantee that nursing schools receive the financial and they need to continue their operations. Failure to enact this legislation will assuredly result in the closing of some schools.

Nursing schools throughout the Nation have sent representatives to the various congressional hearings in order to stress the importance of the Nurse Training Act. Oral and written correspondence on behalf of the program has been numerous.

The administration's bill, in accordance with its efforts to reduce Federal spending, limits Federal aid to the preparation of nurse practitioners and special projects. Nursing programs should be considered by the administration as a health priority now that the trend is for nurses to assume a bigger role in health care services. Today's nurses often perform the functions which have been traditionally associated with the role of a physician.

A nursing revolution is taking place and in some instances nurses are setting up independent practices.

A shortage of well trained nurses, which would insure if H.R. 1143 is not approved, will result in a decline in the quality of health services. The preventive and paramedical role of nurses professionals is widely recognized. They are being trained in highly technical and sophisticated areas such as prenatal care, premature births, burns therapy, care for the aged, and others.

If H.R. 1143 is rejected it is expected that many educational programs will be terminated and students currently enrolled will be unable to complete their studies thus resulting in a disastrous financial burden for both the students and the schools.

Puerto Rico's demand for nurses increases daily. Concern over the future of the nursing programs have been expressed to me through numerous letters, telegrams, and phone calls.

Deans of various schools have contacted me on numerous occasions to point out the problems that will result if H.R. 1143 is not enacted. Students are insecure about their future as nurse professionals and their morale and academic achievement has been adversely affected.

There is a demonstrated need for health professionals. We are and will continue to support this segment of higher education. I believe that health services is an important segment of our society and should not suffer a fate at the hands of budgetary constraints.

The well being of our people is at stake.

Mr. WAXMAN. We would like to hear from Dr. Henry Foley, Administrator Health Resources Administration of the Department of Health, Education, and Welfare.

We welcome you.

STATEMENT OF HENRY FOLEY, PH. D., ADMINISTRATOR, HEALTH RESOURCES ADMINISTRATION, PUBLIC HEALTH SERVICE, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, ACCOMPANIED BY DANIEL F. WHITESIDE, D.D.S., DIRECTOR, BUREAU OF MANPOWER

Dr. FOLEY. Thank you, Mr. Chairman.

Mr. Chairman and members of the subcommittee, I am pleased to be here today and to have the opportunity to present our views on proposed legislation that would extend Federal nurse training authorities through fiscal year 1980.

The present nurse training authorities as contained in title VIII of the Public Health Service Act, are administered by the Bureau of Health Manpower of the Health Resources Administration of the Public Health Service. Accordingly, I am accompanied by Dr. Daniel F. Whiteside, Director of the Bureau of Health Manpower.

Mr. Chairman, the administration's nurse training bill for 1980 supports a targeted approach to Federal assistance for nurse training. This approach recognizes an adequate aggregate supply of nurses and focuses Federal resources on problems of geographic shortages.

This bill also assures that nursing students will be eligible for financial assistance on the same basis as other health professions students. We are supporting this same strategy for all health professions training in order to focus support on those programs that will result in the better distribution of health professionals to medically underserved areas.

The administration bill would authorize appropriations of \$13 million for fiscal year 1980 for the training of nurse practitioners who are currently in short supply. These professionals are trained to provide primary and preventive care, practicing either in complementary or, under certain conditions, substitute roles for physicians. Nurse practitioners have proved to be a cost effective means of increasing the availability of primary care services especially to underserved areas where they often locate.

Fifty percent of a sample of 1974 graduates were employed in either inner city or rural locations. Many nurse practitioner programs include a rural or inner city clinical training component which gives nurses experience in these areas.

In addition, the Rural Health Clinics Act of 1977 provides for independent reimbursement of these health professionals in such settings. The bill would also authorize appropriations of \$1.743 million for fiscal year 1980 for special projects including projects to improve the geographic distribution of nurses, to increase the representation of individuals with disadvantaged backgrounds in the nursing profession, to develop innovative nursing techniques emphasizing primary care and prevention, to enhance clinical skills, to provide continuing education opportunities and to provide advanced nurse training.

The administration's bill would also expand student assistance opportunities for nursing students. The bill would eliminate the 10-percent limit on National Health Service Corps Scholarship support available to health care practitioners other than physicians and dentists.

This program offers large scholarships with a definite service commitment and has proved to be the most effective means available for attracting health professionals to underserved areas.

In addition, this bill would broaden the health education assistance loan authority to include nurses in graduate programs and would repeal a restriction on the eligibility of nursing students for national direct student loans.

These proposed changes, along with the current general student assistance programs, including basic and supplemental educational opportunity grants, administered by the Office of Education, would assure nursing students access to financial aid on the same basis as all other undergraduate and graduate health professions students.

In contrast to the administration bill, H.R. 1143 and H.R. 1651 would extend at authorization levels of \$209 million and \$182 million, respectively, the full array of expiring authorities under the nurse training provisions, title VIII, of the Public Health Service Act.

The authorization levels in H.R. 1143 exceed by approximately \$200 million the nurse training funding requested by the President for 1980. The graduate level support and general nursing student assistance programs proposed for extension by H.R. 1143 are inconsistent with the administration's efforts to reduce Federal spending and to modify its health professions training policy to focus limited resources on programs designed to increase the emphasis on primary care nursing and to alleviate geographic maldistribution.

Although the appropriation authorizations in H.R. 1651 for fiscal year 1980 are somewhat lower than those in H.R. 1143, they still exceed by over \$160 million the amounts proposed in the administration bill. H.R. 1651 also includes authorizations for fiscal year 1981.

For the past 22 years, the Federal Government has provided substantial support for nursing education. From 1956 through 1978, about \$1.5 billion dollars has been awarded for student traineeships, loans, and scholarships; for construction and basic support for nursing education programs and for projects to improve nursing education and recruitment.

With the help of this Federal support, there has been a marked increase in the supply of nurses in recent years. Graduations from nursing education programs have more than doubled since the enactment of the Nurse Training Act of 1964. In addition, an increased proportion of the nurse population is actively employed in nursing today.

Through actions of the private, State and local governmental sectors, combined with prior Federal assistance, we have put in place the capacity to produce an adequate supply of nurses to meet future needs. Recent Congressional Budget Office and HEW analyses of nursing supply and demand have concluded that the supply of nurses through 1985 and 1990 respectively, is likely to be sufficient to meet the demands resulting from probable changes in the health care system.

The administration thus opposes the continuation of general subsidies to nursing schools. It is the administration's view that Federal support for health professions training should focus primarily on service commitment scholarships and direct placement of needed health professionals in scarcity areas through the National Health Service Corps.

For students not wishing to undertake such commitments, the health education assistance loan program in the Office of Education is available.

Mr. Chairman, due to the relative adequacy of current and projected nursing resources, the limited impact of Federal assistance

on increasing the overall supply of nurses, the inability of increased aggregate supply to meet the problem of maldistribution and the President's desire to control unnecessary expansion of the Federal budget, investment in the acceleration of the output of professional nurses no longer competes favorably with more pressing health priorities.

The administration currently is conducting a major review of its support for health professions training with the aim of developing a new legislative proposal covering various HEW programs affecting health manpower training for fiscal years 1981 and beyond which address problems particularly of geographic and specialty distribution.

We have been looking not only at how the health professions programs help meet our needs but also at their relationship to other Federal programs or policies that affect the supply of health professionals.

The implications of various types of health care financing schemes for the supply and distribution of professionals still need to be considered. Finally, we must take into account the effects of health professions programs on future health service costs.

Mr. Chairman, the administration's manpower proposal will take account of the key part played by nurses in the provision of health care in our society.

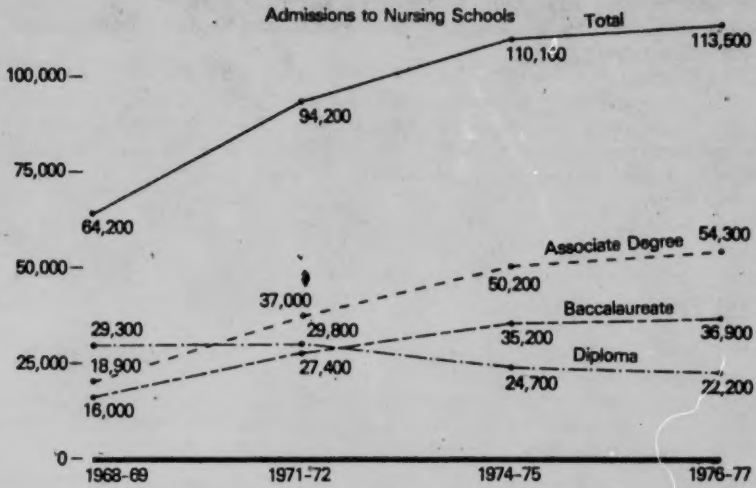
Nevertheless, we believe it is essential to use the necessary extension of nurse training authorities to make midcourse corrections in the evolution of an appropriate Federal role in nursing education.

Congressional consideration of the comprehensive health manpower amendments may not be concluded until the end of this Congress. The need for redirection of Federal nursing programs as well as the current economic climate and the shared executive and congressional resolve to decrease the Federal deficit lead us to urge the Congress to enact the administration's legislative proposals to provide focus to our nurse training activities.

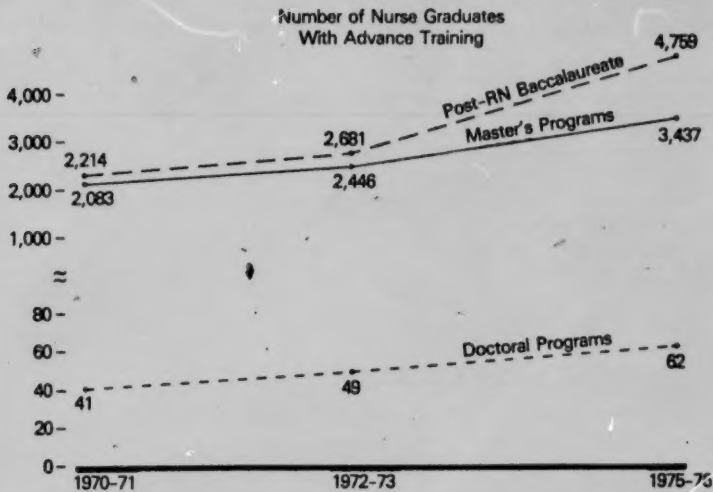
This concludes my prepared statement, Mr. Chairman. Dr. Whiteside and I would be happy to answer any questions the Committee has.

[Attachments to Dr. Foleys' prepared statement follow:]

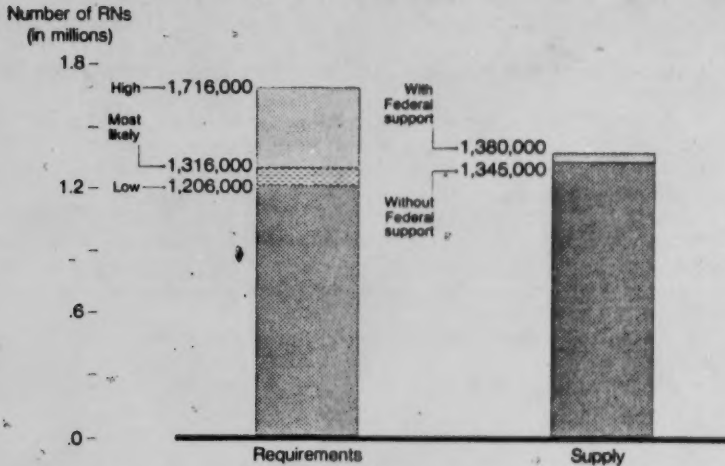
Admissions to Nursing Schools Have Increased



The Number of Nurses Graduating With Advanced Training Is Higher



**On Balance, by 1985 the Aggregate Supply of Nurses
Will Fall Within the Range of Aggregate Demand**



Mr. WAXMAN. Thank you.

Dr. Carter?

Mr. CARTER. Thank you, Mr. Chairman.

You say the administration at this time is trying to cut back on excess expenditures. Is that correct?

Dr. FOLEY. Yes.

Mr. CARTER. In view of what we read in the papers every day about billions being expended in other areas, I rather doubt the veracity of that. It seems startling that you would make that statement when we see in every paper we pick up expenditures of billions of dollars in other areas.

Approximately how many students will have to look for other sources of support if the authorizations for loans and scholarships under the Nurse Training Act are discontinued?

Dr. FOLEY. The current number of students who are not now receiving student assistance either from the Office of Education programs or other resources, private as well as State, would have to seek assistance through the grant-in-aid offices in the various universities and community colleges.

The Bureau of Health Manpower this past year has conducted training sessions for the grant-in-aid officers to prepare them to help inform students on funds available to them.

Currently, we have 8,914 students who are receiving nursing scholarships. Those who have not yet completed their education, would have to seek aid through the grant-in-aid office within the universities and the community colleges through the National Health Service Corps or through other sources.

Mr. CARTER. Almost 9,000 nurses would have to seek other ways of obtaining funds to go to nursing school. Is that correct?

Dr. FOLEY. We have 8,914 students who are receiving nursing scholarships and 16,874 students who are receiving nursing loans

in fiscal year 1979. Of this number, 6,686 students who received scholarships and 12,656 students who received loans, would have to seek aid through the financial aid officers within the universities and community colleges for fiscal year 1980.

Mr. CARTER. Has the administration requested a corresponding increase in other educational loan and scholarship programs to pick up all those who would have received nurse training support otherwise?

Dr. FOLEY. The Administration has proposed an increase in the funding of other programs but not to compensate for this proposed change in program. The nursing students will compete with other students for the funds.

There are increases in fiscal year 1979 in the basic education opportunity grants and there are increases in the supplemental educational opportunity grants, the work study program and the guaranteed loans. There are fairly significant increases. There are decreases in some areas.

Mr. CARTER. What is the total amount of these increases, if you please, sir?

Dr. FOLEY. If I could, Dr. Carter, I would like to submit that for the record.

[The following information was received for the record:]

AMOUNTS APPROPRIATED

[In millions of dollars]

Program	Fiscal year 1978	Fiscal year 1979	Amount of increase
Basic educational opportunity grant	2,140.0	2,600.0	+ 460.0
Work study	435.0	550.0	+ 115.0
Supplemental educational opportunity grant	270.1	340.1	+ 70.0
National direct student loan	310.5	310.5	
Guaranteed loans	530.2	714.3	+ 184.1
Total increases			+ 829.1

Mr. CARTER. All right, sir.

In your recent report on nursing supply, I note on page 99 the following statement which refers to need for prepared faculty, administrators, researchers and clinicians.

Further study is now required to determine the future supply and requirements for these nursing personnel."

Why is it then that you propose to eliminate federal support for advanced nurse training in view of this statement?

Dr. FOLEY. We do not propose its elimination. We propose that the authority be put under the special projects area. Those programs would be eligible as well as the programs that affect the recruitment and training of the disadvantaged and programs to alleviate geographical distribution and their training.

Mr. CARTER. It is not eliminated, just diminished, is that correct? In fact you would authorize less than \$2 million for the entire special projects category which is now authorized at \$115 million.

Dr. FOLEY. Diminished in this year, Dr. Carter, because of the fiscal constraints.

Mr. CARTER. What fiscal constraints?

Dr. FOLEY. The fiscal constraints that the President feels are essential.

Mr. CARTER. I do not see that there are any from what I read in the paper.

How would you evaluate the results of the special project authority?

Dr. FOLEY. Grants that we have awarded in this area have resulted in the decentralization of the educational experience for some of the nurses; some of these programs have been tied to the area health education centers. We have also seen a more creative approach in the recruitment of minorities into nurse training. Perhaps Dr. Whiteside will want to expand further.

Mr. CARTER. I think that is adequate. Are there additional national objectives which you feel could be accomplished through this authority other than those already authorized?

Dr. FOLEY. Current authorities allow us the flexibility to influence both the choice of practice location the type of training received. For example, under the existing advanced nurse training authority, which we have incorporated in the special project authority in our proposal, we have influenced, with the help of the deans of nursing in the country, provide for the training of nurses in geriatrics, and in community health and in nutrition.

We would expect those types of directions continue under the special projects authority.

Mr. CARTER. I notice you want to change the National Health Service Corps to increase enrollment of other health professionals beyond the 10 percent limitation that now exists, is that correct?

Dr. FOLEY. Yes, Dr. Carter.

Mr. CARTER. I have no objections to that, but in response to your desire to do this, how many nurses have you placed in a rural setting up until this time, under the aegis of the National Health Service Corps?

Dr. FOLEY. We have a number of nurses who we have recruited into the scholarship program—a little over 270. We are proposing moving that up in fiscal year 1979 and 1980 to approximately 600.

Mr. CARTER. Is the 270 figure the entire enrollment for the 3 years or do you mean 270 graduates?

Dr. FOLEY. It is 275 recruited into the program through fiscal year 1978.

Mr. CARTER. You have 100 now enrolled?

Dr. FOLEY. We have 192 enrolled in school in four categories, nurse practitioners, nurse midwives, public health nurses, and baccalaureate nurses.

Mr. CARTER. Under the National Health Service Corps, you have, 100 nurses right now in training. How many have you placed in medically underserved areas? We have had the National Health Service Corps for several years. How many do you have in place, out in the rural and deprived areas for which the National Health Service Corps really was established?

Dr. FOLEY. Dr. Carter, I believe we have 39 in the field.

Mr. CARTER. That is a great number for the 435 congressional districts in the United States!

Dr. FOLEY. I would like to be sure and submit it for the record. [The following information was received for the record:]

Dr. FOLEY. The current figure is 67.

Mr. CARTER. That is a tremendous accomplishment!

Thank you, Mr. Chairman.

Mr. WAXMAN. Mr. Preyer?

Mr. PREYER. Thank you, Mr. Chairman.

Dr. Foley, I think all of us agree that budgetary constraints as you mentioned are going to require some cutbacks in the health field as well as others. As the Chairman indicated, we will be considering some fundamental questions on that in the health manpower bill.

What concerns me is after years of very substantial support for nurses, rather than phasing in these cuts or having some agreed on rationale for them, you are in effect totally cutting them off right with one fell swoop without any sort of phased in plan reduction.

You mention in your report that the administration is currently conducting a major review of its support for health professions training and until that is completed, it seems rather drastic to, in effect, eliminate all support.

It gets back to the studies you rely on, HEW and the CBO studies, which you say indicate no shortage of nurses in 1985 to 1990.

I received some newspaper clippings that say there is a shortage of nurses around the country. I know newspaper clippings are anecdotal rather than statistical analyses, but I wonder how sound your HEW and CBO studies are given this indication of shortages.

Are those studies in such form that they could be submitted for the record?

Dr. FOLEY. Yes, they are, both the report we have submitted from the Secretary to the committee and also the back-up documents, particularly the Pugh Roberts study, the Vector study and the WICHE study could all be part of the public record. They are public documents. We would be glad to submit them to the committee.

[The three studies just mentioned are available from the Department of Health, Education, and Welfare under the following titles: The impact of health system changes on the Nation's requirements for registered nurses in 1985, January 1978, DHEW publication no. HRA 78-9; Comparative analysis of four manpower nursing requirements models, January 1979, DHEW publication no. HRA 79.9; and Analysis and planning for improved distribution of nursing personnel and services, panel of expert consultants: final report, June 1978, Western Interstate Commission for Higher Education, P.O. Drawer P, Boulder, Colo. 80302. A copy of these publications may be found in the subcommittee files.]

Mr. PREYER. What is your confidence in the authenticity of the figures in those studies?

Dr. FOLEY. I think they represent the best approach so far by not only including the health economists and the statisticians but also the nurses and the deans of nursing from the respective colleges in the country, particularly in the Pugh Roberts study and the WICHE study.

We have looked carefully at the number because those are what the debate has been about. We think the figure of approximately

1,100,000 active nurses which is the full-time equivalent of about 900,000, is an adequate number right now.

The administration does not propose to reduce the opportunity for nurses. We are saying that nurses should use the resources that are in the Office of Education programs, the grant and scholarship programs which I indicated in my testimony.

We are specifically addressing ourselves to the capitation issue and to the level of support scholarships as well as advanced nurse training.

We are saying that the capitation program helped build capacity in schools of nursing, which we think will continue. We see the evidence of State support. Capitation currently pays for 8 to 10 percent of schools of nursing's fiscal support. We think that this amount can be covered by the States by other funding sources, and perhaps even by increases in tuition.

The job market is available there. I am impressed that if you look at a directory, the yellow pages for example, you will find in the District area, lists of hiring of agencies that recruit nurses and place them in jobs. If we have that number of hiring agencies, there must be a pool of nurses both active and inactive that can be drawn upon to place particular vacancies.

As we look the movement to merge hospitals and merge wings of hospitals, and look at the staffing levels of those hospitals, we are beginning to see in some areas of the country what is now being experienced in the Province of Ontario in Canada, that the staffing size is being reduced.

A specific example is Akron, Ohio, where the community through their health system agency got their hospitals to agree to merge their activities and the staffing level for nurses is being reduced.

Our concern is that as we move to constrict the rapid expansion we have seen in the growth in the hospital industry, we will see a decrease in the number of job slots in these particular hospital settings. Hospital settings now account for 61 percent of the placement for nurses in the country.

Those factors were not considered in the first study I alluded to, the Pugh Roberts study. There was no discussion about the impact of the reduction in utilization in hospitals that we have had in the last 5 years. We have now brought that to bear in our report to this committee and to Senator Kennedy's committee.

We are looking at other changes that are occurring in the health care industry right now which may affect the need for the numbers of nurses.

I am impressed by the American Hospital Association study which indicates that although the number of beds in the last 4 years has been going down in the country, the total number of full-time equivalent personnel in hospitals is going up rather significantly.

The number indicates that not only are nurses coming into the health care field, but allied health professionals are performing some of the functions that nurses did before, as well as some of the physicians' functions. We have whole ranges of health professionals within hospital structures as well as outside hospitals who are now providing care.

We are entering into a discussion with your committee as well as with the Senate Labor and Human Resources Committee and the House and Senate Appropriations Committees, not just of nurses alone and not just of physicians alone, but of the whole pool of health professionals and what then ought to be the numbers.

In our report we are recommending the figure of approximately 1,205,000 to 1,395,000 over the next 5 years.

Mr. PREYER. I agree that it is a worthy endeavor to approach health manpower and womenpower in that fashion. It seems to me that statistics can switch so suddenly. They say statistics do not always lie but they seldom voluntarily tell the truth.

I think we will want to take a close look at those studies.

We see the same thing in the doctors hospitalization where for years we legislated on the basis of the 50,000 shortage and suddenly it vanished and it is a surplus. It never went down to a 40,000 shortage or 20,000, it disappeared overnight.

This seems to be the same sort of thing. When did we change from shortage to surplus? Did anybody ever notice the change in there?

That is why I think we should be very cautious. Maybe all of your analysis is right and maybe the hospital system will adjust this way and so forth and maybe it will not.

Mr. CARTER. If you will yield, according to their own study, they will not be in balance until 1985, a matter of 6 years from now. That is according to a recent report by HEW.

Dr. FOLEY. We have not, either in this committee or before the Appropriations Committee, testified to the existence of a surplus of nurses. We have testified to an overproduction in the area of physicians, particularly in terms of the production of subspecialists in the country.

I have been very clear not to testify that there is a surplus of nurses in the United States. We are saying the capacity is there. We recognize that the Federal dollars that have been authorized over the last decade have led to the building of the capacity within schools of nursing, particularly at the associate degree level and the baccalaureate level.

We think those resources will continue because there is a job market out there. We are not suggesting we have a surplus of nurses in the United States. I do not mean to imply that.

Mr. CARTER. Of course not. Your report shows you do not have a surplus.

Mr. WAXMAN. Any further questions?

Mr. PREYER. I might ask one more. As the Federal Government expands its role in preventive and primary care, which I think we would all salute you for doing, is it not ironic that you are cutting back on the professionals who are most likely to be skilled in preventive and primary care?

I know in my State of North Carolina, there are a lot of areas that would not be getting any primary care if it were not for the nurse practitioners. I am glad to see your emphasis on that in this bill. But where you have cut back so drastically on your overall funding, are you not actually working against your intention to strengthen primary and preventive health care by such drastic cuts?

Dr. FOLEY. With the exception of the area you have indicated of nurse practitioners, at least for fiscal year 1980 we would be in fact not enhancing that movement to primary care. Consistent with Dr. Carter's concern about getting nurses into areas of Kentucky, we want to be sure that any Federal dollars spent do result in the placement of these nurses in primary care in shortage areas.

The current capitation and scholarship programs do not lead to improved distribution of nurses.

I would hope in future years, when we do not have the fiscal constraints, to be here testifying for a greater involvement on the part of the Federal Government in the direction of primary care but with the assurance that the dollars that you would authorize and that would be appropriated would actually result in the placement of these nurses in the underserved areas.

Mr. PREYER. Thank you, Dr. Foley.

Mr. WAXMAN. Mr. Dannemeyer?

Mr. DANNEMEYER. Do you have any figures that indicate the comparison of nurses per unit in hospitals in England and in this country today?

Dr. FOLEY. I do not have them with me, Congressman. The English, as you are probably aware, have gone through various changes in terms of how they have looked at their staffing patterns.

At one point, they used to assign a nurse to a whole ward. They went then to a one to one relationship, with one nurse having primary responsibility for a given patient. Then they returned to basically the nurse serving staffing of a certain number of patients in the ward arrangement and found this pattern quite effective.

We have been experimenting with having our staffing more on a one to one basis in this country. Sometimes this is done for pure clinical reasons; in other cases, the reasons are not as clear.

Questions about nurse staffing are debated within the nursing profession and not just in the Federal Government. Our concern about the ratio is not only for the English but also in some of our own States. In California, there has been some experimentation going on with hospitals in the San Joaquin Valley. They have looked at staffing patterns and specifically nurses.

Mr. DANNEMEYER. Thank you.

Mr. WAXMAN. Mr. Leland?

Mr. LELAND. Dr. Foley, I would like to associate myself with the comments that were made by Dr. Carter, Mr. Preyer and the Chairman in terms of the concern about the proposed cuts.

This thing has been bothering me for some time. I was working for a hospital in Houston for about 6 months. One of my responsibilities was to help them with the difficulties they were having with immigration of foreign nurses to be employed at that hospital.

They were having problems in recruiting American nurses and they had to go to Canada, the Philippines, and England for them.

I would like to ask a question, how do you justify or is it computed in your figures that the adequate supply of nurses also includes foreign nurses in this country?

Dr. FOLEY. We have taken that into consideration. The total number of registered nurses in 1977 was 1,401,000; of that, 52,000 were foreign trained, 3.7 percent.

Mr. LELAND. Are we not getting into a very dangerous area? We are talking about 52,000 people who come here from foreign countries to displace American born citizens who want to practice nursing here? Are we not setting a dangerous precedent when we advocate the cutbacks of funding for opportunities for our nursing students to become practicing nurses in this country?

It seems to me the importation of foreign nursing students or foreign nurses provides a severity of problems by encouraging our nurses to be placed in other job markets.

Dr. FOLEY. We clearly are concerned about the number of foreign health personnel coming into this country. It has been discussed in this committee as well as other parts of the Congress in the last 3 years.

I think our case basically and it is a case that you are questioning here, is we believe that by promoting the use of the other funds coming out of the Office of Education, targeting in that area, we will not be cutting off nursing opportunities for nursing students. We are really saying this particular type of funding—the capitation and the scholarships that are earmarked for a specific profession—really is not the right way to go because we do not get those nurses placed in the geographically underserved areas, whether they are in the inner city or the rural area.

We are not saying students should have Federal support cut off. We are saying they should have that support under the Office of Education programs.

We are working with the grant-in-aid officers in the universities to alert them to these resource so when nurses or candidates for nursing come in, they can apply for those funds as everyone else has.

Mr. LELAND. I understand. It still bothers me that we are talking about 52,000 people. My colleague, Ms. Mikulski, has restated my position in more eloquent terms, she said it shows a dramatic need for more nurses. I am talking about the importation of nurses. They are not displacing American citizens from jobs. They are taking the place more or less, of opportunities for the American people.

We obviously do not have enough nurses to fill those positions and therefore as a matter of fact, we need the kind of assistance programs that we have had in the past.

Dr. FOLEY. We have enough, Congressman Leland. While I grant you that in the area of registered nurses and practical nurses it is unemployment, we still have approximately 3.4 percent of practical nurses unemployed at any one point in time and 1.8 percent of registered nurses unemployed.

There are nurses out there looking for jobs. They are switching jobs and they are in the market looking. If we had that tight a market, you would not even have the 3.8 percent but you would have a much tighter situation.

Mr. LELAND. I do not understand why we are recruiting foreign nurses.

Dr. FOLEY. I think we are recruiting them because we have areas that have too many hospital beds. Congressman Waxman mentioned Los Angeles. There are 4.9 beds per 1,000 there. There are 5.1 beds per 1,000 in San Francisco.

We have situations where we have bed occupancies so low that hospitals are not able to remain fiscally viable. A part of these hospital costs their staffing cost. Many of those hospitals as they are converted and merged will not have the need for the staff they have right now.

My concern—and I share this with you and would like your help because you represent the people, you run for office—is that in this whole debate that we have been carrying on for 3½ months, with the administration making proposals on physicians as well as nurses, we have yet to hear from constituents who are not nurses or hospital administrators.

I agree with Congressman Preyer that this is a delicate sensitive area. We think we are moving in the right direction. We try to make our case that way.

There is always room for questioning. I have yet to hear outside of the nursing lobbies and outside of the hospital administrators, the patients or consumers in this country saying they need nurses or that because of a shortage of nurses their care is being damaged.

Ms. MIKULSKI. I hear from them, in the process of probably 18 town hall meetings throughout my district on health care and particularly the role that allied health professionals, specifically nurses, could play in prevention, in services to the elderly and to young people.

My constituency relates to the cost issue but not sacrificing quality. I go out and talk to the people. My people are blue collar people. Many of my people cannot speak English. They do not write to OMB. They do not know what OMB is, with all due respect to OMB.

I presume this is his time so I am not going to continue.

Dr. FOLEY. That is helpful. I appreciate that.

Ms. MIKULSKI. My pleasure.

Mr. LELAND. I just have one final question. There is a serious problem in maldistribution particularly with minority nurses, is that not correct?

Dr. FOLEY. Yes, there is, Congressman.

Mr. LELAND. It seems to me in such a program of support that encourages and inspires nursing students to go into their fields minority students are the first to respond.

At the same time, when you cut back on programs like that, they are the first to drop out and have no incentive to go into programs of nursing, and medicine.

To what degree is this going to hurt the efforts of affirmative action in terms of recruiting minority students into the field of nursing?

Dr. FOLEY. We have indicated in a previous question that we feel very strongly that special projects should continue to support recruitment of minorities into schools of nursing.

We also have the program for educational assistance to disadvantaged students, approximately \$19 million, which is targeted to recruiting and retaining minorities in all the health professions, including nursing.

The real question I have and I have, heard this from some but not all deans of nursing is minority students who are currently in programs will drop out if these cutbacks go through.

On what basis would they drop out? We are not cutting off their resources in terms of the Office of Education programs. In fact we would take away the statutory restriction in the previous authorizing legislation which said that a student who attended a school with a nursing student loan program under title VIII could not receive an Office of Education loan or grant. We are saying that this restriction should be removed and should not be penalized in this way.

It is not clear to us that minorities will in fact be detrimentally affected by this. What could happen is black colleges and black nursing schools that are receiving capitation will have a very difficult time in their fiscal support. I want to differentiate that.

Mr. LELAND. I am glad you said that.

Dr. FOLEY. I think I have to.

Ms. MIKULSKI. Will the gentleman yield so I can perhaps clarify that? When minorities or people who have never been included in the system think about higher education, they really think about it in junior high and high school.

If you are a guidance counselor in Glochispil, Ala., and you are trying to think about how you can start working with that 14 year old black girl who has never had anybody give her the support and encouragement to make it, when no one in her family has never finished high school let alone college?

When you pick up the Alabama Times and read that the nursing education has been cut, you do not know something might be available under title such and such and if you can whistle Dixie or whatever, first of all, the kids see that. They see that education which will be their first step up and out is being cut and the guidance counselor says, I do not know whether I should really advise these kids to go into health care because budgetary constraints this year as outlined by OMB says it is not going to be around.

We are talking about the very constituencies that you want to be nurses. You have to start when those young people are 12 and 13.

Dr. FOLEY. I agree.

Ms. MIKULSKI. They need to see some type of long range comprehensive plan, that is available and is readily understandable and not be reading headlines that President Carter has cut them and vetoed nursing education. That is why young people feel like they do not need that help.

I think the gentlemen primarily from rural areas would be able to speak to that even more eloquently.

That is why you are getting the reaction as if we are trying to stay the messenger here.

Dr. FOLEY. I think you are absolutely on target in terms of the public image. We are trying to do something about this problems, targeting \$20 million and to be exact, \$19,068,000, on recruitment and retention of disadvantaged students, going all the way down to the 8th and 9th grade in that effort.

What happens too often I think you are absolutely on target, is that the counselor does not know what studies of financial resources are out there. We need to do a much better job in telling them of the availability of resources regardless of what the decision is here.

We need to do that so the counselor is encouraged and knows those opportunities are there for that particular population.

Mr. LELAND. Is it not true, Dr. Foley, that the demand for the student aid funds under the Office of Education exceeds the funds available?

Dr. FOLEY. Yes.

Mr. WAXMAN. Thank you, Mr. Leland.

Ms. Mikulski, do you want to use some of your time or do you want to yield some of it?

Ms. MIKULSKI. Perhaps Mr. Leland and I are going to end up as flex time Congress Members.

I just want to make a few points, if I may, Mr. Chairman.

Dr. Foley, I really do not envy your position because I think you are here representing a position that perhaps you yourself may or maynot embrace it personally and what has not been so much a function of not what HEW has advocated but what OMB has decided.

It is an invisible source of government that we do not even know and that is not even held publicly accountable for the recommendations they make.

You have my sympathy in terms of your position. I fundamentally disagree with the administration on two principles or policy analysis here.

No. 1, the need and No. 2 the functions that other scholarship programs provide. I would just comment that in terms of other scholarship programs and for any of us who are involved in meeting educational needs in rural or urban America, I can tell you those things that you talk about in the Office of Education are really a boondoggle in many ways. They do not get to the very people who need it.

That series of assumptions I think, is quite faulty. Second, in terms of need, we can talk about the amount that is needed but what you and I would agree with is we have to have a better geographic distribution of nurses to the rural and particularly southern and underserved urban regions.

What I cannot figure out in all of this is quite frankly how does this program really meet this, the program you are advocating?

Dr. FOLEY. If I could respond to that, in three areas. First, with respect to the expansion of the nurse practitioner program, we do have a track record. Over 50 percent of those graduates do in fact end up practicing in rural and urban areas.

I come from Colorado, one of the areas where nurse practitioners are serving in the National Health Service Corps. There is a place called Dove Creek on the Utah border. The closest physician is 120 miles away in Cortez. He comes in once a week. The nurse practitioner basically takes care of the regimen of care for the patients during that week or two while the physician is not there.

That program shows us that we can in fact place this type of professional in underserved areas particularly where there are not physicians.

We feel very strongly about the special projects area in terms of getting commitments of people to practice—

Ms. MIKULSKI. Would you elaborate on that part of it?

Dr. FOLEY. Some special projects complement area health education center projects and provide for the decentralized training of nurses in rural settings. For example, in Congressman Preyer's State, North Carolina, there is a very successful AHEC program in which nurses are very much involved. The nurses do a lot of their training in field sites.

We have seen through other studies, particularly concerning of physicians, that if we recruit somebody from a specific rural or inner city area and also by race and train them out in those areas, there is a greater likelihood they will stay in those areas and practice.

We would like to continue in that direction.

The third area that Dr. Carter is concerned about and I am, too, is the National Health Service Corps where because of the budget I am here to defend, we do not have the kind of expansion that might be appropriate to place nurses in these various places where they would not normally go, as part of their service requirement.

I think that you and I would agree, Congresswoman, that one of the faults in the Office of Education programs is that after we have put out the money for the students, we have no assurance that they are going to practice in the areas which are geographically underserved.

My plea to you as a committee, even if you go against the administration's proposal, and I hope you do not, but if you do, I think it is time for us to consider linking our dollars to a service requirement. Someone will be up here 10 years from now recalling that 10 years ago, the same committee was debating how are we going to deal with geographical distribution. I am here to plea that we begin now to link the dollars that the Federal Government spends for student assistance a service requirement.

I think that is consistent with the administration's position. That is what we are strongly recommending.

Ms. MIKULSKI. First of all, I would agree with you on that. I think we then can also link that with other opportunity requirements.

This administration did not really develop the comprehensive policy in terms of primary care. I know we are going to be considering legislation on CHAP which I think offers unprecedented opportunities for nurses to be involved in early detection, screening, et cetera.

You cannot have a nickel and dime approach in one area and also talk in terms of manpower. I happen to think there is tremendous opportunities for nurses that will ultimately result in the containment of costs because of the early detection, because of screening, because of getting involved in running poison control centers that prevent hospitalization and untold human hardship.

We have to be able to link those two up. The jobs are in communities to work with the poor. We then will have the people to do it.

If you do train a nurse, the doctors are out there practicing beltway medicine, the hospitals are out beyond the beltway, when the nurse wants to get a job, she is going to go look out where the beltway is or where the doctors and hospitals are.

I yield my time to Mr. Leland.

Mr. WAXMAN. Your time is expired.

Mr. Gramm?

Mr. GRAMM. I would like to go back to the point made by my distinguished colleague from North Carolina. I would like to assert an answer to his question.

His question was a very simple question. He has been in the Congress for a long time. In all this period we have been talking about a nursing shortage. Suddenly, it is gone.

I want to assert why it has gone. It is not gone because there is in reality no nursing shortage. Barbara mentioned a problem in rural areas. There is not a hospital in my district and I represent a rural area in Texas, that does not have a nursing shortage, not one.

Those shortages are generally on the second and third shift where folks do not want to work. They have a shortage.

I assert that the reason we have had this massive change in public policy, the reason you have come here today and told us there is no nursing shortage is not because the market system has changed, not because the shortage has been eliminated but because there has been a change in public policy.

I assert that the change in public policy is based on idea that you are not going to count these rural shortages in my district because you want to shut those hospitals down.

Dr. FOLEY. No.

Mr. GRAMM. Under the guidelines issued by HEW last year which created a furor in my State, many of the hospitals in my district would have shut down.

I assert the real change which has occurred has been a change whereby you have this idea that you are going to eliminate these excess hospital beds and those eliminations are going to fall primarily in the areas that have a nursing shortage.

I would like to ask you to respond to that assertion.

Dr. FOLEY. Mr. Congressman, that is not the case at all. That is not either an oblique or a secret policy. It is not the policy of this administration to close hospitals in rural areas.

There was an issuance back in September of 1977 of guidelines that I think were inappropriately worded in the sense of the message, misinterpreted. We went through a process of public comment and received 55,000 letters. We read those letters. We built the responses into our planning process. We came back and revised those guidelines twice. A year ago, in March of 1978, we came out with guidelines which explicitly state that the conditions have to be defined by the local county in terms of those national guidelines. We were very explicit about not talking about closing rural hospitals. That was a charge being made by many in the hospital industry, on the basis of a misinterpretation of the administration proposal.

I am here to tell you that this proposal in terms of nursing is not linked to any strategy to close rural hospitals.

Mr. GRAMM. Is it linked to a strategy that we are now calling hospital cost containment?

Dr. FOLEY. It is linked to an approach both in the Government and in the voluntary sector as well—a voluntary effort as well as the administration's cost containment proposal—looking toward reduction of staff size in certain hospitals as they either merge or

convert wings or in some areas close OB/GYN service because there is not as much population growth in those particular areas.

We have seen the voluntary effort begin to have an impact on hospital staffing levels. We would expect that effort to continue.

We would assume that under the administration's proposal on cost containment or any national health insurance that had a cost containment mechanism in it we would see some impact on staffing patterns within hospitals.

Mr. GRAMM. You are saying, in part, that the elimination of this shortage, which we see in the marketplace, is going to come in part as a result of government policy and hospital cost containment and national health insurance.

Dr. FOLEY. I am being direct and suggest it is going to happen in one or two ways. It is already happening in the voluntary sector without Government intervention. It could as happen as a result of Government intervention, if there were Government intervention.

Mr. GRAMM. I would like to go to another point.

It seems to me when you are talking about the number of nurses, you are talking about a pool of potential nurses. It seems to me you are missing the point, which is, we cannot force people to engage in nursing. Therefore, we have to look at labor force participation rates and not just pools.

Before asking my question, I would like to simply point out that as an old school teacher, I was somewhat concerned when you were stating that the existence of hiring agencies shows the supply exists. In fact, I would assert that the existence of hiring agencies and long ads in the newspaper shows a demand exists.

Dr. FOLEY. There must be nurses looking for jobs. Otherwise these hiring agencies would go out of existence, Congressman.

Mr. GRAMM. I have Sunday's ads right here. We have employment ads for RN's, LPN's, nursing opportunities, head nurses and the Washington Hospital Center. I have an article from the Houston Chronicle and I would assert Houston is a big city with the best medical system in the world and Mr. Leland would agree on that.

It says the basic reason for the shortage is that while there are a large number of registered nurses here, there are only a small number willing to work.

One might misinterpret "willing to work." I would assert that you cannot count Mickey Leland in the number of pharmacists. You cannot count me in the number of school teachers. You have to count the number of people who are actually willing to work at the prevailing wage.

It seems to me when you are talking about these figures in terms of the number of nurses that you are missing the point. It is not how many people have an RN degree. It is the number of people who are willing to work in the marketplace at the prevailing wage.

Dr. FOLEY. I would agree with that. I am not fighting that or disagreeing with that statement.

I think we have to look at that carefully. We do not want to be coming back here in 10 years and still discussing the fact that we are producing all of these nurses but many of them are unwilling to work because the wage scale is not adequate. Nurses are one of the lowest paid professional groups in the health industry today.

To train more nurses does not guarantee that the nurses will practice in the particular hospitals that need them in the inner cities or rural areas.

Production of nurses will go on anyway out there in the State and community colleges. Our question is how to target our Federal dollars so we will make sure that the nurses who are will practice in the areas where we need them to practice.

Mr. GRAMM. I would like to go to another point. This is the geographic distribution. It seems to me that when we are talking about a problem of geographic distribution, it is very easy to say it does not have anything to do with the overall problem of whether there is a shortage or not.

I do not believe that. I believe that if we cannot get nurses in Mexia, Texas, if we cannot get nurses in Waxahachie, it shows me there is no surplus in Dallas, that there is no surplus in Houston. The whole history of this country indicates that people are willing to move to find a job or at least they were until we started paying people not to work through the welfare system.

Our whole history shows that if there is a surplus in one area, that surplus will, by natural decisions that people make to better their condition, that they will move to other areas.

I would assert that the geographic distribution simply reflects the shortage in general. It reflects the fact that if there is a shortage in supply and if wages are being controlled directly or indirectly by government policy, people are going to seek out the best working conditions.

If I am an RN and I have "N" opportunities, I would rather work in the exciting medical center in Houston.

I would say the fact that people are not opting to go to Waxahachie, Mexia and Corsicana is that we have a shortage and the shortage is not showing up in the exciting nursing centers. It is showing up in the fringes.

I think what you are calling the geographic problem is in fact a shortage problem.

Dr. FOLEY. It is certainly a shortage problem in those areas where nurses are not practicing. I agree.

Mr. GRAMM. If there were an excess supply in Dallas, if you had too many nurses in Dallas, why wouldn't they move to another town to take a job?

I am saying if you look at any labor market, when there is a shortage, people are going to choose the most desirable jobs and a shortage always shows up in the fringe areas, in the areas that are viewed by that professional to be the least desirable, on the third shift.

You would say if we have a shortage of people working on the third shift, that is not really a shortage. It is just that people do not want to stay up at night. I am saying that is not true. I am saying as long as people can find jobs on the first and second shift, in general, they are not going to take the third shift.

These fringe areas in my mind are clear cut evidence that there is a shortage and the shortage is showing up in those areas. You are writing that shortage off by one of two logics. One is the logic that you deny, and that is, you are going to shut those hospitals down anyway or, two, the logic which says this is a geographic

problem and what we ought to do is force people to go to those areas.

Dr. FOLEY. What I am arguing, Mr. Congressman, is that of the total capacity we as a Federal Government, Congress and the Executive Branch, have helped to build in the last 10 to 15 years will stay in existence, students will go to these nursing schools and the schools will produce the numbers that are adequate for this country.

We are not recommending a cutback in the capacity of schools of nursing. We are not saying the number of slots should be reduced. That statement has not been made. We have never said that the number of nurses being trained should be reduced.

I am suggesting that with this capacity in place the students would use other funds available to them to pay for their training, precisely because there is a job market available to them when they get finished, in contrast to some other areas where the students are being trained in colleges, and community colleges in this country today.

Nurses know there will be a job at the end when they graduate, whether it is at the AA level or the Bachelor level.

Mr. GRAMM. Mr. Chairman, if you will indulge me, my final point has to do with the fact that you are not hearing from outsiders, that you are not hearing about nursing problems from people other than nurses and hospital administrators.

I think we have gotten into the logic in government that unless we get a letter from somebody then problems do not exist. I think that is a very naive viewpoint.

When I go to find somebody to work on my car, I do not write to the Federal Government if I cannot find a qualified person.

I just do not think people that are not directly involved know very much about the problem. I think to say, people who are directly involved in something have such a vested interest that their viewpoint should be discounted and what we want is some totally disinterested person's viewpoint is not appropriate.

Dr. FOLEY. I did not say that. I asked a question of the Committee and I got a good response. There is no question that as a professional in a Federal Administrative post I have to listen to information from nurses and from hospital administrators. I am saying that is not enough and we should have more information.

I would not want to go to get all my information about oil from the oil industry. I would want to have other forces looking at that. I think the same is true in professional areas.

If I were to go only to the physicians of this country to find my information about medical practice and what should be the numbers of certain types of subspecialists, I would have no balance. That is why in the Graduate Medical Education National Advisory Committee we have invited not only subspecialists and hospital administrators but also health economists and others to look at physician speciality needs.

We certainly want to have the professional viewpoints shared, and that is why we presented the studies to the committee, the Pugh Roberts Study, the Vector Study and the WICHE Study.

I think we also want to hear the kind of information that Congresswoman Mikulski shared with us. There are other people out

there who are equally interested. That does not denigrate the case for nursing. It may very well make the case.

We are just asking for that type of information.

Mr. LELAND. Will the gentleman yield?

Mr. GRAMM. Surely.

Mr. LELAND. Dr. Foley, whose responsibility is it to hear from those people and to gather information from those other people?

Dr. FOLEY. I think it is the responsibility of all of us, mine as well as yours.

Mr. LELAND. We have the responsibility to appeal to our people, to hold townhall meetings and to respond to the questions that are asked of us.

If you are the advocate of health in this country and you are directly charged with that responsibility, is it not the case that you should be out there in the grassroots community holding hearings and talking to the community, getting responses from them?

Are you not accountable to them as well?

Dr. FOLEY. Yes, we are, Congressman. We are suggesting, particularly in the Bureau of Health Manpower, both in the area of physicians and nursing as well as allied health, that we do have hearings in the various regions in the country to gather more information, not just as a one-time effort but a regular activity.

Mr. LELAND. In light of Mr. Gramm's assertions, the most prominent problem in my mind is the inadequate supply of nurses in the rural counties.

I know that in 39 counties of Texas there are no nurses, no doctors, and no health facilities, et cetera.

Are you willing or should I say have you gone into those areas to find out what is the response of the people there and what they feel their needs are, in light of the shortage of nurses?

Dr. FOLEY. We have begun that process with the health systems agencies. We have begun to ask them to identify not simply capital formation needs but also the specific services they want in a specific geographic area and the person power it takes to provide those services.

One of the things we were concerned about, and will be discussing in relation to health planning next week, was that in a lot of the plans we were getting, there was a numeration of the types of services they want. For example, in Minneapolis/St. Paul, they talked about wanting pediatric services. They did not discuss how many pediatricians they needed, how many nurses, midwives, et cetera.

We are now asking, if you are going to put that in your plans and you want to effect that in the community, look at how much person power it takes, whether it is in a rural area or in an urban area. We are now assessing those plans. We use that vehicle to get that information.

Mr. LELAND. To what degree are you also educating the people as to what their health needs are?

Dr. FOLEY. I think we are beginning, now having gone through the stage of formulating HSA's in this country in the last 3 years, with the exception of a couple places, to use HSA's as a vehicle for education around health, not just prevention but in the area of acute care as well.

Mr. LELAND. Mr. Chairman, I yield back the balance of my time.

Mr. GRAMM. I do not know that I have any time left. I just simply would like to point out that I am concerned that the administration is too concerned about limiting demand and imposing controls.

It is my belief that our problem in the medical care system is a supply problem and not a demand problem. We have a commodity that has a very high income elasticity. People want medical care.

I am concerned if we are going to move toward giving it away, which is the clear direction we are moving toward in this country, we are going to have to produce tremendous amounts of it.

It is my opinion that what we need to be doing instead of cutting back our effort on nurses' training, is expanding that effort, upgrading nurses into positions between RN and the physician, developing paramedical personnel for a whole range of areas so we can provide the American people with a high quality Chevrolet kind of medicine.

I am convinced if we take the approach that we are going to limit demand, we are going to end up having a detrimental impact on quality.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you. We also want to hear from others in addition to the administration. If we do not move on, we will not get the opportunity.

Dr. Carter has another question or two.

Mr. CARTER. I do have a short question.

How many registered nurses today are working full time according to your report?

Dr. FOLEY. I think it was a little under 900,000.

Mr. CARTER. I believe that number is 854,000 working full time.

You estimate that by 1985, the Nation's needs are going to be 1.2 to 1.3 million nurses. That is 500,000 more than you have at the present time. Between now and then, I expect we will lose a great number by attrition.

It appears me that we may even have a deficit of nurses at the present time and in the future.

Dr. FOLEY. We also in the report share the number of nurses we are producing each year and the attrition factor that we think is accountable. I do not think we have lost over that by any means.

Mr. CARTER. I do not see those figures but I would like to review them.

Dr. FOLEY. We would like to supply it for the record.

[The following information was received for the record:]

SUPPLY PROJECTIONS

As of January 1977, the estimated number of registered nurses in the supply was 1,011,000. However, while there were more than a million registered nurses, the actual full-time equivalent supply was 854,000 because of the large number who can only work part-time.

The following tables present the projections of the supply and the full-time equivalencies for registered nurses under two sets of assumptions about anticipated graduations from educational programs preparing nurses. The first set of data of (Series I) reflects the impact of withdrawal of present levels and types of Federal support on current trends in the output of graduates from the nursing educational programs for registered nurses. The second set (Series II) presents the anticipated supply in terms of the maintenance of current conditions and trends in graduation.

Projections of national active supply of registered nurses, by educational preparation (Series I), 1977-1990

As of January 1	Total number of nurses					Full-time equivalencies				
	Total	AD & Dip.	Bacc.	Master's and above	Nurses per 100,000 pop. 1/	Total	AD & Dip.	Bacc.	Master's and above	Nurses per 100,000 pop. 1/
1977	1,011,000	797,400	175,800	37,800	467	854,000	664,800	153,900	35,400	395
1978	1,059,000	825,200	192,500	41,000	486	895,000	687,800	168,500	38,300	411
1979	1,106,000	852,300	209,300	44,100	503	935,000	710,200	183,200	41,300	426
1980	1,152,000	878,500	225,900	47,300	520	971,000	731,600	197,600	44,300	439
1981	1,195,000	901,400	243,500	50,600	534	1,010,000	749,900	212,700	47,300	451
1982	1,238,000	922,600	260,900	54,000	548	1,045,000	766,900	227,700	50,500	463
1983	1,276,000	941,000	277,800	57,500	560	1,077,000	781,500	242,200	53,800	472
1984	1,313,000	957,400	294,300	60,900	570	1,108,000	794,400	256,300	57,000	481
1985	1,345,000	971,000	310,100	64,400	579	1,135,000	804,800	269,700	60,200	488
1986	1,376,000	982,800	325,600	67,900	587	1,161,000	814,100	283,000	63,500	495
1987	1,405,000	992,900	341,100	71,600	593	1,185,000	822,200	296,200	67,000	501
1988	1,433,000	1,001,200	356,600	75,300	600	1,209,900	828,800	309,400	70,500	506
1989	1,459,000	1,007,700	372,000	79,100	605	1,230,000	833,700	322,500	74,100	510
1990	1,484,000	1,012,800	387,600	83,100	611	1,251,000	837,700	335,800	77,800	515

1/ Population projections were obtained from U.S. Department of Commerce, Bureau of the Census, Projections of the Population of the United States, 1977-2020, Series P-25, No. 704, July 1977. Series II projections as of July 1, adjusted for armed forces overseas, were used.

Source: Estimates prepared by Division of Nursing, Health Resources Administration, U.S. Department of Health, Education, and Welfare, 1977.

Projections of national active supply of registered nurses, by educational preparation (Series II), 1977-1990

As of January 1	Total number of nurses					Full-time equivalencies				
	Total	AD & Dip.	Bacc.	Master's and above	Nurses per 100,000 pop. 1/	Total	AD & Dip.	Bacc.	Master's and above	Nurses per 100,000 pop. 1/
1977	1,011,000	797,400	175,800	37,800	467	854,000	664,800	153,900	35,400	395
1978	1,059,000	825,200	192,500	41,000	486	895,000	687,800	168,500	38,300	411
1979	1,106,000	852,300	209,300	44,100	503	935,000	710,100	183,200	41,300	426
1980	1,152,000	878,800	226,100	47,400	520	974,000	731,900	197,800	44,300	439
1981	1,199,000	903,400	244,500	50,700	536	1,013,000	751,600	213,600	47,400	453
1982	1,245,000	926,800	261,600	54,200	551	1,052,000	770,700	230,100	50,700	461
1983	1,290,000	948,900	283,500	57,900	566	1,090,000	788,700	247,300	54,100	478
1984	1,336,000	969,900	304,100	61,700	580	1,128,000	805,600	265,100	57,700	490
1985	1,380,000	989,200	325,400	65,600	594	1,166,000	821,100	283,400	61,400	502
1986	1,424,000	1,006,500	347,300	69,600	607	1,203,000	835,500	302,300	65,100	513
1987	1,466,000	1,022,900	369,600	73,800	619	1,239,000	848,500	321,600	69,100	523
1988	1,507,000	1,037,900	391,500	78,100	631	1,274,000	860,500	340,400	73,100	533
1989	1,548,000	1,050,200	414,700	82,500	642	1,308,000	870,600	360,400	77,300	543
1990	1,587,000	1,061,500	438,500	87,200	653	1,342,000	879,500	380,900	81,700	552

1/ Population projections were obtained from U.S. Department of Commerce, Bureau of the Census, Projections of the Population of the United States, 1977-2050, Series P-25, No. 704, July 1977. Series II projections as of July 1, adjusted for armed forces overseas, were used.

Source: Estimates prepared by Division of Nursing, Health Resources Administration, U.S. Department of Health, Education, and Welfare, 1977.

Mr. CARTER. Since you are going to use the National Health Service Corp's as a vehicle for increasing the number of nurses in deprived areas, how much are you recommending that we increase the authorization for that particular program this year?

Dr. FOLEY. I believe the administration's figure is \$79.5 million as the total amount.

Mr. CARTER. That is the total amount, but what is the increase over last year that you are recommending? How does the amount available to nurses for scholarships compare with rescission figures?

Dr. FOLEY. The rescission that both Houses have acted upon?

Mr. CARTER. Yes. It appears that you are not increasing support in the areas of need.

Dr. FOLEY. Yes.

Mr. CARTER. Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Dr. Foley.

Without objection we will insert the documents you have now into the record and will insert the other documents you are going to supply for the record when they are received.

Mr. FOLEY. Thank you, Mr. Chairman. I appreciate the time.

Mr. WAXMAN. We will now hear from a panel representing the nursing profession. The panel consists of Mary Lohr, Dean of the University of Michigan School of Nursing, Ann Arbor, Mich.; Constance Holleran, American Nurses Association, Washington, D.C.; Rose Hauer, Director of Nursing Services, Beth Israel Medical Center, Perlman Place, N.Y.

We would like to welcome you to the meeting today.

STATEMENTS OF MARY LOHR, ED. D., DEAN, UNIVERSITY OF MICHIGAN SCHOOL OF NURSING; ROSE M. HAUER, R.N., M.A., ON BEHALF OF NATIONAL LEAGUE FOR NURSING; AND CONSTANCE HOLLERAN, AMERICAN NURSES ASSOCIATION

Ms. LOHR. Mr. Chairman, I am Mary Lohr, Dean of the University of Michigan School of Nursing. Prior to this post, I was privileged to be Dean of the University of Virginia School of Nursing and subsequently Dean of the University of Illinois College of Nursing.

My professional career began at Downey Hospital, Downey, Ill., where I was first a staff nurse and moved to the ranks of head nurse and nurse supervisor.

I am very grateful for this opportunity to come before such a well informed committee.

Mr. WAXMAN. Excuse me. I would like to mention to the witnesses that we each have a copy of the testimony you have submitted to us. The full text will be made a part of the record. We would ask you to summarize in 5 to 10 minutes the essential points you want to highlight so we can have more of an opportunity for questions and answers.

Ms. LOHR. Thank you, Mr. Waxman. It is what we have each planned to do.

Mr. WAXMAN. Your statement will be inserted into the record.

Ms. LOHR. I am very grateful for this opportunity to come before you and to talk with you on a subject of great importance to the future of health care delivery in this country.

I appear today to urge prompt enactment of H.R. 1143 or any similar or identical bill to extend Federal support for nurse training.

Last year, legislation for support of nurse training was passed by Congress and subsequently pocket vetoed by President Carter. The budget proposed by the administration for fiscal year 1980 limits support to preparation of nurse practitioners and special projects.

If Congress supports the administration's recommendations for nurse training, it can be expected programs preparing nurses will be closed and students enrolled in these programs will be unable to complete their education. It can be expected that this will lead to a situation in which the documented shortage of nurses will increase and precipitate a marked decline in the quality of health care delivery.

Throughout this country, there is general recognition that costs of health care are rising and there is widespread dissatisfaction with both availability and quality of health care. Without prompt improvements in health care systems, it can be anticipated health services will deteriorate and public demands for these services will become increasingly urgent.

Any curtailment of support for nurse training will aggravate the situation in which availability and quality of health care is already less than optimum.

One essential area is support for advanced nurse training. Programs preparing nurses for advanced practice are in each State of the Union and no two are exactly alike. Some programs have a clinical focus preparing nurses for specialized practice in a specific age group such as the care of infants. Others emphasize fields of specialties throughout the age spectrum such as the nursing care of burn patients.

It is also within these advanced programs that teachers of nurses, administrators of nursing services, and deans of schools of nursing are prepared.

In addition to the preparation of clinicians for specialized practice and administrators, programs providing advanced nurse training also emphasize development of competencies needed to generate new knowledge from research and apply this knowledge to problems which are encountered in clinical practice and in administrative practice.

Nursing research has great potential for cost containment.

Nurses prepared in programs supported by Federal funds for advanced nurse training are having an impact upon both the quality of patient care and the health care cost containment.

I have some examples. I will shorten the examples because of the timeframe.

Nursing research evidence produced by Dr. JoAnne Horsley, Professor of Nursing, University of Michigan, School of Nursing, indicates that specific kinds of preoperative patient instruction significantly alters postoperative recovery by reducing length of hospital stay; reducing post-hospitalization confinement at home, preceding return to normal activity such as work activities and fostering in the patient a general feeling of well being and satisfaction which is in itself a therapeutic in its impact.

In another study, two nurses developed and instituted a systematic plan for coughing and deep breathing exercises for patients following abdominal surgery which resulted in a 40 percent reduction in average length of hospitalization.

When they altered further the administration of narcotic analgesics and instituted post-operative exercises, an additional 5 percent reduction in length of hospitalization occurred.

If you wish to have this study, I can make it available to you.

Assuming the average length of hospitalization for abdominal surgery is 11.9 days and utilizing the conservative estimate of \$100 per day for hospital charges, a 40 percent reduction in length of stay would mean discharged 4.8 days earlier and a reduction of \$480 in costs per patient.

There are many other significant ways nurses can help to reduce health care costs. I will not go into this now. You have other documents.

Mr. WAXMAN. We will break for 5 or 10 minutes to answer a quorum call in the House.

[Brief recess.]

Mr. WAXMAN. The subcommittee will come to order. Dr. Lohr, did you have something more you wished to add?

Ms. LOHR. Mr. Chairman, I will submit my materials for the record and defer to my colleagues.

[Testimony resumes on p. 66.]

[Ms. Lohr's prepared statement follows:]

STATEMENT OF MARY LOHR, E.D. D.

Introduction

MR. CHAIRMAN, on behalf of the profession of Nursing, I appear today to urge prompt enactment of HR 1143, or any similar or identical bill to extend Federal support for Nurse Training. I am grateful for the opportunity to come before this Subcommittee on a subject of great importance to the future of health care delivery in this Country.

Last year, legislation for support of Nursing was passed by Congress and subsequently pocket vetoed by President Carter. The budget proposed by Administration for fiscal year 1980 limits support to preparation of nurse practitioners and special projects. If Congress supports Administration's recommendations for support of Nurse Training, it can be expected programs preparing nurses will be closed and students enrolled in these programs will be unable to complete their education. This can be expected to lead to a situation in which the documented shortage of nurses will substantially increase and precipitate a marked decline in quality of health care delivery.

Within the United States, an increasingly sophisticated public is demanding that quality health care be made accessible to all. There is general recognition and widespread apprehension regarding rising costs of health care and widespread dissatisfaction with availability and quality of health care delivery. It seems likely that unless there are prompt improvements within health care delivery systems, health care services will deteriorate, and public demands for changes in health related services will become increasingly urgent. This testimony is aimed toward making explicit some salient relationships between Advanced Nurse Training, Nursing Research, quality patient care at reasonable cost, and federal support for higher education in Nursing.

Advanced Training for Advanced Practice

Support for Advanced Nurse Training is utilized to prepare clinical specialists, educators, administrators, researchers and nurse practitioners. The 1980 federal budget provided \$12,000,000 for grants in these areas. However, the 1980 budget recommended by administration is that there be no support. This critical area should be authorized and funded at no less than \$14,000,000 for fiscal year 1980.

Current centers of Advanced Nurse Training contribute to improvement in quality of health care in the United States by (1) creating new nursing knowledge from research and integration of research findings into the total bank of nursing knowledge; (2) transmitting knowledge to new generations of nurses both in general and specialized nurse training; (3) applying knowledge to provide solutions to nursing problems in the form of applied research; and (4) promoting positive health values and practices. Even at the current modest rate of federal support for Advanced Nurse Training, shortages of nurses with special skills and academic credentials will not soon be corrected.

Despite an increase in the number of programs leading to the Ph.D. in Nursing, the total of newly graduated Ph.D.s has been decreasing for several years. Although enrollment in master's program continues to increase, the number of nurses choosing to prepare themselves for advanced clinical practice is having an adverse effect on the supply of nurses interested in teaching or administration. Throughout the country, schools of nursing have hundreds of unfilled, budgeted positions; and in addition, the preparation of a significant proportion of school of nursing faculties is not adequate, with only 5.3% of all faculty members holding an earned doctorate. The 83 programs currently funded by DHEW Advanced Training Grants make important contributions to the

development of a distinguished corps of nurse-educators, nurse-administrators, and nurse-practitioners. Programs to train professional nurses for initial or advanced practice are conducted in every area of the United States, and are by far the most prevalent form of health manpower preparation. These programs constitute an unparalleled national resource for maintaining and advancing the nation's health and undergird national defense capabilities for times of crisis. Nurses with advanced training are knowledgeable in areas of health and human behavior, are prepared to provide health teaching, and coordinate community health services. Availability of nurses with preparation in these areas help meet the needs of a sophisticated public and "... transform America's present health care system from one that limits itself to the treatment of sickness into one that stresses preventive health."¹

If federal funds for support of Advanced Nurse Training are curtailed or become unavailable, a significant proportion of programs throughout the Nation preparing nurse specialists to care for pregnant women, the newborn, and for persons throughout the age spectrum in need of personal and specialized services can be expected to dramatically diminish. For example, the University of Michigan School of Nursing stands to lose 36% of its budget (\$1,037,359) if this support is cut off. Annual support for programs currently supported by the Nurse Training Act at the University of Michigan is as follows:

1. The Pediatric Nurse-Practitioner Program	\$ 93,966
2. Master's Program in Psychiatric Nursing	121,603
3. Nursing Capitation	113,823
4. Master's Program in Parent-Child Nursing (An Advanced Nurse Training Grant)	212,107
5. Master's Program in Community Health Nursing (An Advanced Nurse Training Grant)	215,086
6. Student Support	280,774

¹ Kalisch, Philip A. Issue Paper on Fiscal Year 1979 Advanced Nurse Training and Nursing Research Discussions: Status as of March 5, 1979.

Effects of losses in support for Advanced Nurse Training would be devastating for the University of Michigan School of Nursing, as well as for other innovative and effective advanced training programs for nurses throughout this country.

Implications of Nursing Research
for
Quality Patient Care
and
Health Care Cost Containment

The 1978 report of the Committee on a Study of National Needs for Biomedical and Behavioral Research Personnel recognizes nursing research as a "distinct area of scientific inquiry" and describes nursing research as that which:

... focuses on the role of nursing care in the prevention of illness, care of the sick, and the promotion and restoration of health. Although it relies upon and utilizes the substantive scientific information and methodology provided by the other biological and behavioral sciences, it differs from those other scientific areas in that it focuses on their relevance to nursing rather than other aspects of health care. (NRC, 1975-77: 1977 report, p. 152)¹

It is at the graduate level (master's and doctoral) that nurses are prepared for research which has relevance for the practice of nursing.

Findings from nursing research are having an impact upon the quality of patient care and health care cost containment. One major research project conducted by a distinguished group of nurse researchers led by Dr. JoAnne Horsley, Professor, University of Michigan School of Nursing, outlines areas in which nursing research and nursing's subsequent utilization of research-based knowledge has had an impact on the quality and cost of patient care services:

¹ Personnel Needs and Training for Biomedical and Behavioral Research - 1978 Report, pp. 128, 129.

Postoperative Recovery. There is considerable nursing research evidence that indicates that specific kinds of preoperative patient instruction significantly alter postoperative recovery. Patient recovery is affected in the following ways:

1. Length of hospital stay is reduced.
2. Length of post-hospitalization (home) confinement preceding return to normal living/working activities is dramatically reduced.
3. Respiratory function is enhanced.
4. Amount of pain medication requested (and used) by patients is reduced.
5. Patients' general feeling of satisfaction with their health care is greatly enhanced. (Although "satisfaction" per se does not directly decrease health care costs, it may have an indirect affect by reducing malpractice suits. This relationship needs further exploration.)

Diarrhea Associated with Tube-Feeding Therapy. Nursing research evidence clearly demonstrates a positive relationship between the use of lactose-based tube-feeding diets and incidence of diarrhea. This is especially true in minority patient populations. (Diarrhea is a health care complication which increases the potential risks of incontinence, bed sores and fluid and electrolyte imbalance.)

Prevention of Bedsore Formation. A body of research indicates that a nursing procedure consisting of shifting body parts in patients who are at risk of developing bedsores (e.g., immobile, unconscious or malnourished patients) can result in a significant reduction in bedsores formation.

Prevention of Infection. Prevention of urinary tract infection. The most common site of nosocomial infection is the urinary tract. Considerable research has shown that when nurses use a closed sterile urinary catheter drainage system, the incidence of urinary infections can be reduced from a high of 95% to a low of 15-25%. Reduction of infection by use of such a system in nursing settings can subsequently reduce (1) length of stay, (2) expensive antibiotic treatment; and (3) potential for chronic renal damage.

Venous Infection Associated With the Use of Intravenous Cannulas. There is research evidence that indicates nurses can significantly alter the incidence of venous infection. This evidence suggests that incidence of venous infection is directly related to the length of time an intravenous cannula remains in a vein without being changed. Nurses who have initiated patient care regimens based on this research have substantially lowered the incidence of venous infection in their patients. (Venous infection is a health care complication which results in increased hospital stay and expensive antibiotic treatment.)

Examples cited make obvious that nursing is making and can continue to make substantial contributions to cost-containment efforts in the health care field while also enhancing the quality of care received by our citizens.

In another study by Katherine R. Jones on "The Effect of Primary Nursing on the Postoperative Adaptation of Renal Transplant Patients," the investigator found that patients respond more quickly to major surgery and with fewer problems when one nurse is responsible for their care throughout the period of hospitalization. The investigator describes this care as primary nursing. In this study, patients that did not receive primary nursing averaged 4.6 complications and were hospitalized 48.6 days while those who received primary care developed 1.4 complications and experienced only 26.7 days as a mean length of hospital stay. In one hospital this approach to nursing care saved \$61,085 in hospital costs for nine patients. The Jones study demonstrates that nurses can be instrumental in reducing costs of hospitalization by facilitating early recovery after surgery and early discharge from confinement. Furthermore, this investigation suggests early recovery and decrease in complications is a justification for employment of professional nurses capable of meeting the psychological and physical needs of patients rather than relying upon less qualified personnel.

Jones is one nurse researcher looking at staffing patterns in relation to impact upon quality of care and cost of care. This investigator is among the pioneer nurses concerned regarding availability of health care. Nurses within this avant guard are concerned with the long standing problems of redistribution of nursing services and are focusing upon various aspects of problems such as investigating alternatives to institutional care of the aged, relevant health care delivery for ethnic persons of color, and increasing the number of nurses qualified and willing to work with underserved groups such as the elderly. Any withdrawal of federal support for research which impacts

delivery of patient care would curtail investigations in these and other significant areas of inquiry, reduce quality of health care delivery, and counteract health cost containment efforts.

Construction Support

For fiscal years 1978 and 1979, Congress authorized \$20,000,000 for "construction, replacement or rehabilitation" of facilities for the preparation of nurses. No construction funds were in the 1978 and 1979 appropriations. However, there continues to be an urgent need for support of construction of School of Nursing facilities. Throughout the country, facilities available for the teaching of nursing pose serious constraints upon the excellence of educational programs. Most critical space problems are shortages of classroom space, deficiencies in laboratory and research facilities, and lack of space for continuing education offerings for nurses who wish to enroll for short-term intensive instruction aimed toward updating and strengthening clinical competencies.

Capitation Support

Capitation grants are awarded annually to schools of nursing. They are institutional support funds used at the discretion of faculty of individual schools. In 1979, Congress appropriated \$30,000,000 for capitation support for schools of nursing. However, for 1980, President Carter proposes no capitation funding.

Capitation support is frequently used for special efforts aimed to strengthen aspects of a program which need special emphasis and are of particular social significance. For example, throughout the country, faculties of Schools of nursing recognize the importance of curricular offerings which

address cultural differences and nursing care of ethnic people of color. There is an increased emphasis in nursing curriculae upon teaching students ways of assessing the health status of minority clients and approaches to teaching these clients with emphasis upon health maintenance, prevention of illness and nursing care. Capitation funds are frequently utilized to assist faculty to develop programs which address these particular areas. Loss of capitation support can be expected to dilute innovative and creative thrusts within curriculae preparing nurses.

Special Project Support

The \$15,000,000 appropriated in 1979 for special projects was used for such projects as: (a) establishing cooperative arrangements between nursing schools and hospitals; (b) research in nursing education; (c) improving curricula to emphasize pediatric or geriatric nursing; (d) increasing nursing educational opportunities to those of disadvantaged backgrounds; (e) promoting continuing education for nurses; (f) retraining out of practice nurses; (g) improving distribution of nurses; (h) upgrading skills of Licensed Practical Nurses; and (i) developing short-term in-service training programs for aides and orderlies. For 1980, funds which support the above activities have been decreased to a meager \$1.7 million.

Student Support

Traineeships - Awarded to schools of nursing to pay for tuition, fees, and a stipend for training professional nurses as: teachers; administrators or supervisors; nurse-practitioners or clinical nurse specialists, were funded in the amount of \$13,000,000 for Fiscal Year 1979. No funding for 1980 is

included in the administration proposal. This form of student aid should receive the highest priority and be authorized and funded at \$14,000,000 for fiscal year 1980.

Loans and Loan Repayments - Administration proposes no funds for fiscal year 1980 for these categories. Fiscal year 1979 carried appropriations of \$22,500,000 for loans and \$1,500,000 for loan repayments. These programs should be continued at the present levels.

Scholarships - \$9,000,000 was appropriated for fiscal year 1979. No support is requested for fiscal year 1980 within the Administration proposal. This is tragic for students of nursing from low income families. Maintaining a separate program of loans and scholarships for students in schools of nursing in the Nurse Training Act Amendments of 1979 is essential. Students in schools of nursing generally come from upper-lower and lower-middle class families who with insufficient funds to support the education of their children. The unique position of nursing today as a profession in its adolescence, with the concomitant special attention required, makes it extremely desirable to maintain the student assistance program in the Public Health Service rather than refer students to the various loan programs of the Office of Education.

Nurse Practitioner Training - This category has been untouched; the \$13,000,000 appropriated in 1979 for training nurse-practitioners is considered a sufficient amount for 1980.

Essential Federal Support
for
Higher Education in Nursing

Federal support for nursing should focus upon the following:

1. Preparation of nurses to deliver quality health care within inpatient and outpatient settings;

2. Support of research which has relevance for practice and teaching of Nursing.
3. Support for programs preparing teachers in nursing.
4. Support for students through traineeships scholarships and loans.
5. Support for programs preparing administrators of nursing services and administrators of schools of nursing.
6. Facilitation of creative education and research endeavors, to address the maldistribution of nurses, and improve analysis and planning for supply of nurse manpower.
7. Support for Construction.

Conclusion

In conclusion, Mr. Chairman, I reiterate my strong belief that nursing can provide answers to questions of pressing federal importance today. In the legislation that is under consideration here, we are responding to the question, "What should federal support be to optimize health training and health care performance?" To answer this question, we must not place too great an importance on current funding levels, especially since these are a result of extremely hard work by members of the nursing profession eeked out against bitter odds set forth for us by the Administration. Current funding, in other words, bears little sense of reality when compared with either actual needs or potential contributions of nursing.

I call, therefore, for restatement of the total authorization under the earlier Nurse Training Act, which would now be conservative in view of inflation, and suggest that an authorization of \$200,000,000 for fiscal year 1960 would be a minimum to achieve national goals for a changing health care system that requires competent nurses with advanced training and the findings of nursing research. The benefit to cost ratio of nursing is very high, perhaps the highest among the health professions. It is within the power of this committee to promote a strengthened contribution in the nursing field with knowledge that for every dollar authorized there is an unusually high rate of return.

Mr. WAXMAN. We will now hear from Ms. Hauer.

STATEMENT OF ROSE M. HAUER

Ms. HAUER. I am Rose Hauer, Director of Nursing Services at Beth Israel Medical Center, testifying on behalf of the National League for Nursing, a coalition of nurses, allied health professionals, consumers, and health agencies. There are 17,000 individual members and 1,900 agencies dedicated to developing and improving the standards of quality nursing education, nursing services, and health delivery in the United States.

Among its functions, the league acts as the national accrediting agency for all nursing educational programs for which it is recognized by the Council on Postsecondary Accreditation and the U.S. Office of Education.

Mr. Chairman, let me emphasize at the start that without the strong commitment of the Congress to continue support for nurse training, nursing's contribution to the Nation's health needs in the past years would have been severely restricted.

We are very grateful for this support and trust that now in the light of congressional scrutiny of the persistent nurse shortage, you will see fit to continue Federal assistance.

The supply of nurses has surely been greatly increased with Federal funds over the past 5 years. Nevertheless, it is necessary to look beyond the aggregate data on nurse supply which may demonstrate adequate numbers of nurses but also mask the glaring shortages and maldistribution problems that exist on regional and local levels.

Mr. Chairman, facts do not speak for themselves at all. Numbers are entirely meaningless until they are arranged and structured and patterned, relating to something. To begin with, there are approximately 70.5 percent of licensed nurses who are now employed.

That a shortage of nurses exists is likely to be obvious in a visit to any one of the great majority of hospitals in the Nation, especially if you chose to visit on a weekend. While hospital administrators and directors of nursing may vary in their description of nurse shortage, from severe or acute to moderate, most would agree that the shortage is chronic.

Examples are abundant. In Beth Israel in New York where I am the director of nursing services, in spite of the fact that I was given approval for 25 budgeted positions, I could not find qualified nurses to fill these vacancies.

Subsequently, a House Committee of Physicians was formed because of the grave concern over the nursing shortage. Beth Israel has always been known to provide superb care and the idea that the quality of care could be jeopardized because of a lack of qualified nurses poses a very serious problem.

It is very disconcerting to have to staff a 35 bed unit with only one or two RN's at night. In addition, we have recently expanded our medical-surgical and O.R. facilities requiring skilled O.R. and qualified medical-surgical nurses. Qualified nurses for these positions have been impossible to obtain.

Our concern is safe patient care. Beth Israel Medical Center has 90 percent of its patients covered by either Medicare or Medicaid.

That means 50 percent of our patients are elderly patients, women and men who need a great deal more care than the average patient and unless we have the number of nurses we need, it is impossible to give safe patient care.

We also are known for the largest methadone treatment program in the United States for drug addicts. We are the second largest ghetto area for disadvantaged patients in the lower east side of New York. We also run an alcohol detoxication service. Unless we have qualified personnel to care for these patients, we will run the risk of these patients receiving no care at all.

The withdrawal of Federal funds for nursing in the face of shortages such as these, portends drastic consequences for the health of the Nation. Within the context of anticipated societal changes such as an increase in the numbers of the elderly citizens who already constitute 11 percent of the American population and often require extensive nursing care, this situation can only get worse.

In addition, now that home care is becoming part of the overall strategy to improve the quality of health care at a considerable cost savings, an increased need for nurses to provide this service will be essential.

In nursing education there is currently a zero growth rate in the numbers of nursing schools, applicants, student admissions, and graduations according to the National League for Nursing research statistics. Thus, with no growth in the capacity to produce nurses, there is surely no hope of solving the problems these shortages present.

Continued Federal support is especially important for disadvantaged nursing education. Dr. Anna B. Coles, Dean of the Howard University School of Nursing, has expressed grave concern over the 75 percent of her students receiving Federal aid. She stated, "without assistance, they cannot come to school, even though our tuition is very low. As it is, they go from semester to semester not knowing whether they can return."

Many health experts have noted that with all its scientific advancement, the established medical care system has seen the limits of its effective powers. Answers must be sought now in nonmedical spheres which provide a humane and cost effective alternative.

Historically, expenditures for nurses and health professionals other than physicians have averaged approximately 10 percent of the expenditures for physician services. The cost saving potential of nurses has just begun to be tapped, especially in the area of prevention.

Nurses present a potential solution to many critical health problems in the Nation. Only to the extent that the Congress realizes nursing's potential will nurses be effective in dealing with the problems we face as a Nation in health care.

We wish to stress the need for support for the division of nursing in HEW.

One example I would like to quote of what we are doing at Beth Israel Medical Center is to run a refresher program for nurses because we have such a shortage.

We have had a refresher program for the past 13 years, getting nurses back who have been out of nursing for the past 10 to 15 to 20 years. Nurses who are coming back into the field are saying, it is

almost impossible to work in a hospital today because of the shortage and to give the patient safe care.

Even though they take a refresher course, they are reluctant to come back into a hospital and work in a situation where they cannot give the kind of care which they feel patients should get.

I would like to thank you for this opportunity to testify. I shall be happy to answer any questions you may have.

[Testimony resumes on p. 75.]

[Ms. Hauer's prepared statement follows:]

STATEMENT OF ROSE M. HAUER, R.N., M.A.

I am Rose Hauer, Director of Nursing Services at Beth Israel Medical Center testifying on behalf of the National League for Nursing, a coalition of nurses, allied health professionals, consumers, and health agencies-- 17,000 individual members and 1,900 agencies--dedicated to developing and improving the standards of quality nursing education, nursing services, and health care delivery in the United States. Among its functions, the League acts as the national accrediting agency for all nursing education programs, for which it is recognized by the Council on Postsecondary Accreditation (COPA) and the U.S. Office of Education.

Mr. Chairman, let me emphasize at the start that without the strong commitment of the Congress to continue support for nurse training, nursing's contribution to the nation's health needs in past years would have been severely restricted. We are very grateful for this support and trust that now in light of Congressional scrutiny of the persistent nursing shortage, you will see fit to continue Federal assistance.

The supply of nurses has surely been greatly increased with Federal funds over the past five years. Nevertheless, it is necessary to look beyond the aggregate data on nurse supply which may demonstrate adequate numbers of nurses, but also mask the glaring shortages and maldistribution problems that exist on regional and local levels.

Mr. Chairman, facts do not speak for themselves at all. Numbers are entirely meaningless until they are arranged and structured and patterned, related to something. To begin with, close to 400,000 nurses (approximately 28%) are not employed. Many reasons have been cited such as non-competitive salaries, long and burdensome working hours which are often caused by understaffing and an overabundance of paperwork.

That a shortage of nurses exists is likely to be obvious in a visit to any one of the great majority of hospitals in the nation--especially if one chooses to visit on a weekend. While hospital administrators and directors of nursing may vary in their description of the nurse shortage--from severe or acute to moderate--most would agree that the shortage is chronic. Examples are abundant. I.e., in Beth Israel in New York where I am the Director of Nursing Services, in spite of the fact that I was given approval for twenty-five budgeted positions, I could not find qualified nurses to fill those vacancies. Subsequently, a House Committee of Physicians was formed because of the grave concern over the nursing shortage. Beth Israel has always been known to provide superb care, and the idea that the quality of care could be jeopardized because of a lack of qualified nurses poses a very serious problem. It is very disconcerting to have to staff a thirty-five patient bed unit with only one or two R.N.s. In addition, we have recently expanded our medical-surgical and O.R. facilities, requiring skilled O.R. and qualified medical-surgical nurses. Qualified nurses for these positions have been impossible to obtain.

Other directors of nursing services report similar situations. At Mercy Hospital in San Diego, California, Nursing Director Frances Petersen states that the Special Care Unit has to be closed periodically because there are not enough qualified nurses to staff it. Consequently, some patients have had to stay in Intensive Care for a greater length of time than necessary--a very costly repercussion. Also in California, the medical director of the Burn Unit at Torrance Memorial Hospital, claims that there is a very definite and chronic shortage of nurses in all of Southern California, one of the most affluent parts of the state. He emphasizes that there is an acute shortage of operating room

and critical care nurses. Finally, Health Care Week (January 8, 1979) reported 500 vacant nursing positions in hospitals in Los Angeles County, which shortage has resulted in reducing the number of hospital beds, sending patients to non-county institutions, and hiring part-time nurses from nurse registries.

Southern states suffer the severest shortages. Coastal Georgia papers cite "a critical shortage of registered nurses" in the area (Statesboro, GA Herald, January 31, 1979; Savannah (GA) Morning News, January 31, 1979).

An Albany, Georgia, newspaper (Herald, February 8, 1979) claims that local nursing shortages reflect a statewide problem which is becoming quite serious, with 3,000 vacancies in hospitals all over the state.

North Carolina papers (the Greenville Reflector of January 20, 1979; the Charlotte News of January 20, 1979) recount serious nursing shortages in spite of nearby schools of nursing. These reports recount that Greenville hospitals have been forced to turn patients away because of nurse shortages and that expensive recruitment programs conducted in Canada have failed to relieve the problem.

Even areas of the nation that have the highest ratio of nurses per 100,000 population, such as New York City which I already mentioned, and Washington, DC, constantly battle a chronic shortage of nurses. Florence Deutch, of Washington's Capitol Hill Hospital, reports numerous budgeted vacancies. The American Health Care Association of New York, a trade association representing some 2,000 long-term health care facilities in the state, reports that the nursing shortage is critical in the facilities they represent.

According to 1978 statistics from the American Hospital Association, hospitals in western Tennessee reported that 33 percent of their budgeted

RN positions were unfilled; in Arizona, 21 percent; in California, 17 percent; in Texas, 14 percent; and in the Greater Milwaukee area, 12 percent. Serious concern over the nursing shortage problem has led the AHA to set up an Advisory Panel on nursing shortage, not only to examine the nursing shortage but also to address the use of nurse registries and the increased costs incurred by hospitals using them.

Several state studies have also been conducted indicating nursing shortages. For example, a recent study done for the Nebraska State Legislature has been used by the State Health Planning Agency to recommend an expansion of nursing education facilities in the state.

The withdrawal of Federal funds for nursing in the face of shortages such as these portends drastic consequences for the health of the nation. Within the context of anticipated societal changes--such as an increase in the numbers of elderly citizens, who already constitute 11 percent of the American population and often require extensive nursing care--this situation can only get worse. In addition, now that home care is becoming part of the overall strategy to improve the quality of health care at a considerable cost savings, an increased need for nurses to provide this service will be essential. A recently completed study funded by the Department of Health, Education, and Welfare projects that at least 48% more nurses will be needed to meet the nation's health needs by 1982.

In nursing education there is currently a zero growth-rate in the numbers of nursing schools, applicants, student admissions, and graduations, according to National League for Nursing research statistics. Thus, with no growth in the capacity to produce new nurses, there is surely no hope of solving the problems these shortages present.

Educating nurses also poses formidable problems. At present only 61 percent of full-time nursing faculty have a master's degree or higher (NLN statistics). In addition, over 800 budgeted faculty positions are currently vacant (Congressional Budget Office Report). In a comprehensive study carried out by Lyssaught on nursing and nursing education, a broad area of consensus was identified regarding the major problems of programs in nursing education. Three predominating difficulties were apparent: there is a shortage of qualified faculty; there is a lack of funds and adequate financing; and facilities are outmoded and inadequate.

Continued Federal support is especially important for minorities in nursing education. Dr. Anna B. Coles, Dean of the Howard University School of Nursing, has expressed grave concern over the 75 percent of her students receiving Federal aid. "Without assistance they can't come to school, even though our tuition is very low. As it is, they go from semester to semester, not knowing whether they can return." Studies have shown (May 1978 CBO Report; 1979 HEW study by Dr. Eleanor Feldbaum) that minority nurses contribute more than others to providing better access to nursing care for disadvantaged populations. Dr. Feldbaum's work also shows that employed minority nurses with graduate degrees tend to work in underserved areas for the greatest length of time. Minority nurses are also more likely to work in public health and community health agencies that tend to have low-income and minority clients. With the assistance of Federal funds between 1972 and 1978, the number of newly licensed minority registered nurses has doubled, from 3 percent to 6 percent (NLN research statistics.)

The Carter Administration wisely emphasizes the need for innovative health delivery systems in the nation as well as the tremendous need for primary-care providers. In the world of technologized medicine the patient

is at the mercy of the physician's strict schedule, as well as the mass of diagnostic and therapeutic apparatus. In the Golden Age of Medicine, what is missing is the humanness of the relationship between the patient and physician. Mechanized, dehumanized care further serves to alienate the already dispirited patient, increasing feelings of loneliness and anomie.

Nursing not only represents a break from disease-centered treatment, but holds the promise of restoring the mental and moral force to the health delivery system. Nurses are prepared with a broad and general base in human behavior that is needed to administer primary care. The most fundamental important skill that nursing students today are being taught is the ability to provide effective care to individuals in a variety of settings. The functions of professional nursing include case-finding, diagnostic assessment, care supportive to life and well being, health teaching, individual or family health counseling, therapeutic intervention (psychological or physiological) and restorative services. In addition, they are the only primary care professionals that place such great emphasis on individual values in patient education. At present, 52% of all hospitalizations are said to be stress related. The impact of stress, however, is relative to the individual. Dr. Hans Selye, Director of the International Institute of Stress claims that if stress is properly directed in patient teaching, it is not necessarily bad for you. Stress is a phenomenon that "makes some people tick, and causes others to have heart attacks." In other words, the individual's total patterns of behavior must be examined on a continuous day-to-day basis so that stress can be channeled most effectively to maximize healthy behavior. This is the business of professional nurses. Nurses are health educators who focus on care of the individual rather than on cure.

Many health experts have noted that, with all its scientific advancement, the established medical care system has seen the limits of its effective powers (Fuchs, Who Shall Live, 1977; Ehrenreich, The Cultural Crisis of Modern Medicine, 1978). Answers must now be sought in non-medical spheres, which provide a humane and cost-effective alternative. Historically, expenditures for nurses and health professionals other than physicians have averaged approximately 10% of the expenditures for physician services. The cost saving potential of nurses has just begun to be tapped, especially in the area of prevention.

Nurses present a potential solution to many critical health problems in the nation. Only to the extent that the Congress realizes nursing's potential, will nurses be effective in dealing with the problems we face as a nation in health care.

Thank you for this opportunity to testify. I shall be happy to answer any questions that you might have.

Mr. WAXMAN. Thank you very much.

STATEMENT OF CONSTANCE HOLLERAN

Ms. HOLLERAN. Mr. Chairman, in the interest of time, we do have our full statement for the record and I would like to submit another short statement that is our response to the HEW report which did not become available to us until late last week.

[See p. 89.]

Mr. WAXMAN. The documents will be inserted into the record.

Ms. HOLLERAN. I would like to take 2 or 3 minutes to comment on some of the points Dr. Foley raised this morning for the record. I think the implication of a response to a question by Dr. Carter about the number of students who would require financial aid from another source was less than the number currently being supported under the Nurse Training Act.

There are about 34,000 nursing students currently receiving loans or scholarships.

The other point Dr. Foley made was that of consumer participation in expressing concern about the lack of funds for nurse training. This committee was very supportive of putting back in the proposed cuts for nursing programs on the floor fight and we do appreciate that.

I think you are aware that working with us on that effort were members of consumer groups. Senior Citizens, the Grey Panthers, United Auto Workers, teachers and people from all over the country.

The third point made by Dr. Foley was in reference to the telephone yellow pages and the ads for nurses. The reason I want to respond to that is that I had an experience last Fall with one of the members of the Senate who expressed real concern about the

consumer not knowing what they are getting when they look for nursing care in the home.

This particular Senator had a very unfortunate experience because he thought he was using a nursing agency when in fact they were untrained and unlicensed people, not even trained as aides that were going into the homes to provide service.

The District of Columbia and the State of Texas are the only places in the United States that do not have a mandatory licensing law for nurses. As a result, anybody can call themselves a nurse and it can be very misleading if you are looking at the yellow pages. Dr. Foley needs to carefully study that issue, I think.

Thank you.

[Testimony resumes on p. 94.]

[Ms. Holleran's prepared statement and attachment follow:]

STATEMENT OF CONSTANCE HOLLERAN

We urge prompt enactment of legislation to extend provisions of the Nurse Training Act.

As you know the bill passed overwhelmingly by Congress last year was pocket vetoed by President Carter. The Administration's proposed budget for fiscal 1980 contains no support for any Nurse Training Act programs except special projects and nurse practitioner training. Despite the implied promise in his veto message that funding would not be abruptly cut off during fiscal 1979, the President also proposed rescissions of \$84 million in appropriated 1979 funds.

The result of this action has been concern and confusion among the schools and students. At the very least, this will slow or halt programs and cause students to postpone or cancel their plans for nursing education. A number of schools already have projected specific cuts that will be required if NTA funds are eliminated. Some minority schools have indicated they will have to close.

A school in Michigan estimates that reduction in funds would require dropping of 15 faculty and reduction in admissions of 80 qualified applicants each year.

A "consortium" of nursing schools in North Dakota reports that loss of federal funds would present serious problems for all schools and to efforts to maintain accessible, quality health care in the state. Federal funds have provided substantial support to eight schools involving 1,197 students.

Discontinuation of NTA funds would mean a loss of \$300,000 in operating revenue and student financial aid to one school in Tennessee. The school also reports that a recent survey of hospitals in the area shows a vacancy rate in budgeted RN positions ranging as high as 16.7 per cent.

A school of nursing in Minnesota says that it would lose \$600,000 a year or 26 per cent of its total funding, and the loss will mean discontinuance of a planned doctoral program in nursing, traineeships for masters' students (71 presently receiving such support), and loans and scholarships to students, cuts in admissions, and dropping of faculty.

Emory (Georgia) University's School of Nursing would lose between \$2 and \$3 million dollars in educational and service programs. The graduate program might have to be closed, according to the dean. All special programs would have to go and enrollment in the baccalaureate program would have to be cut. Included among the special program are minority recruitment, family health clinical specialist, community learning experiences, gerontological nurse practitioner (training stipend), and psychological nursing.

A survey of schools of nursing in Nebraska conducted by the state nurses association revealed unanimous concern about the potential impact of loss of NTA funds. Their conclusions: loss of loans, scholarship and traineeship funds "would drastically curtail enrollments; faculty positions would have to be reduced and some secretarial positions would be lost; there would have to be many cutbacks in inter-campus TV and telephone meetings; it will place in jeopardy the educational programs of many students." The Nebraska report also notes that the Nebraska State Health Department's Division of Health Systems Planning has reported an unmet need in the state for 2,707 registered nurses.

Minority schools of nursing at Florida A & M and Tuskegee say they would have to close.

Howard University and Hampton Institute estimate that 50 to 75 per cent of their nursing students would have to drop out.

In a recent survey by the American Association of Colleges of Nursing of 135 schools with baccalaureate and higher degree programs, 48 per cent or 60 schools indicated that loss of federal funds would necessitate dropping programs. Seventy-three per cent or 94 said that loss of federal support would require lowering enrollment.

The University of Iowa School of Nursing, which stands to lose \$300,000 in program support and \$586,000 in student support, says there is a particular need to upgrade preparation of public health nurses in Iowa. Seventy-eight per cent of Iowa's 300 county public health nurses have never had a formal public health course. (Generally such courses are found only as a part of baccalaureate nursing programs.) Public health nurses are increasingly important in the delivery of health care in Iowa. For FY 1978, public health nurses made 142,000 visits to persons over 65 years of age, an increase of 33,000 visits over the previous year. A 19-county survey in Iowa determined that 28 per cent of patients of all ages seen by county public health nurses would need to be permanently in a health care facility if home health care were not available.

These kinds of statistics are repeated in schools throughout the country.

When the President vetoed the Nurse Training Act of 1978, his stated rationale was that "the outlook is good for adequate, sustained growth in the supply of nurses," and thus, "there is no reason for the government to provide special support to increase the total supply of professional nurses."

The fact is that even with continued federal support at approximately current levels we are talking about maintaining current supply and not "sustained" growth. Even with current funding, there is a zero growth rate in basic nursing education admissions and graduations.

Under a mandate in the Nurse Training Act of 1975, HEW commissioned a study of current and future needs for RNs to provide guidance in making decisions about future aid to nursing education. This study, recently completed by the Western Interstate Commission for Higher Education, indicates that if the utilization of nurses is not increased, such as in providing more primary care, and if current levels of funding continue, the supply in 1982 could be in balance. The Study Panel more realistically projects that by 1982 the nation will need 1,219,300 to 1,677,000 FTE registered nurses. The current figure for full-time equivalent RNs is 870,000.

The Bureau of Labor statistics also supports the thesis of an expanding demand for nurses. BLS projects an increase of 240,000 jobs in nursing by 1985.

Directors of nursing services in hospitals and nursing homes continue to report high vacancy rates in RN positions. Stories and classified ads in newspapers across the country testify to a continued high demand for nurses. The state of Texas currently has more than 6,000 foreign trained, unlicensed nurses in charge nurse positions.

As a result of recent changes in immigration procedures, fewer foreign nurse graduates will be entering the country. A decrease of about 4,000 per year is expected.

While a very high percentage of registered nurses participate in the work force and are employed in nursing, newly graduated nurses continue to be able to find employment in nursing within a short period after graduation. Figures for early 1978 show that only 1.9 per cent of newly licensed RNs reported they were seeking employment. At the same time the national unemployment rate range from 6.0 to 6.3 per cent.

A report in the Illinois Hospital Association's February 16, 1979, Legislative Reporter states that there is no surplus of active nurses in Illinois. In 106 Illinois hospitals, the report states, 1,800 budgeted R.N. positions remain unfilled. The IHA report estimates the total number of registered nurses needed in Illinois hospitals as between 3,570 and 3,828.

Hospital employment data collected by the American Hospital Association and analyzed by the American Nurses' Association show that during 1972-77 RN employment by hospitals increased by 33.9 per cent or 144,389 full-time equivalent positions. We believe this increase reflects the intensity and sophistication of nursing care required. The number of days of hospitalization continues to be cut as a result of utilization reviews, etc., so the patients' needs for care in that shorter stay are much greater than even 10 years ago.

Home health agencies also have increased demands for nursing staff. Again patients go home sooner, are sicker and require more extensive and more frequent visits.

In addition to failing to accurately assess the country's demand and need for nursing services, the President's veto of the Nurse Training Act seemingly did not take into account the potential impact on nursing schools and students. There are approximately 1,300 nursing schools in the country and 248,000 students. Schools report that many of the approximately 40,000 who receive loans, scholarships or traineeships under NTA are dependent on this assistance and would have to drop out or postpone their education if alternate assistance could not be found.

This resultant hardship would fall disproportionately on minorities and those from low-income families. A report from the Congressional Budget Office, "Nursing Education and Training-Alternatives Federal Approaches," issued last May notes that "The availability of NTA loans may provide access to a nursing education for those who otherwise could not afford to attend or who cannot obtain loans from other sources." The report states that 66 per cent of the 1974 loan recipients were from families with income of less than \$10,000. Of those recipients, 20 per cent were black and 5 per cent were from other minorities.

NTA scholarships are available to exceptionally needy students. The CBO study says that in 1974, 79 per cent of scholarships went to students from families with incomes of less than \$10,000. The percentages of blacks and minorities were about the same as for loans, and the CBO study suggests

that "the availability of NTA loans and scholarships may have been a major reason for minority enrollment increases in nursing schools." The report points out that the number of blacks enrolled in RN programs began to increase dramatically after enactment of the NTA of 1964 which first provided loans and scholarships.

The CBO study also indicates heavy reliance by RNs enrolled in graduate programs on support available under NTA. In fiscal 1978, \$14 million was available supporting 3,000 students, or over 30 per cent of all full-time students in master's, doctoral or nurse practitioner programs. In many instances, these trainees received only tuition assistance as funding is too low to include the usual stipend.

"A decline over the years in the proportion of students receiving traineeships coincides with a downward trend in the proportion of full-time students enrolled," the CBO report states.

One reason that there is a continuous need for assistance to nursing schools and students is that nursing is not a highly paid profession. Even nurses who have been working for a number of years often cannot accumulate the money necessary to return to school for advanced education. The average staff nurse salary is still only \$11,940. The average for all nurses regardless of position or level of responsibility is only \$12,936.

To help meet the gap caused by its cutoff of funds to nursing students the Administration suggests alternatives. One is to secure scholarships available under the National Health Service Corps. Only 270 such scholarships are available to nurses for the 1979-80 school year. This is fewer than the 385 provided in 1978-79. Nursing has not been included in this program

at all until the last two years. Though the proposed budget provides for some expansion, the total number will still be extremely small. Ninety percent of scholarships provided under the program must go to medical and dental students. We understand the Administration's bill would remove the ten percent limit on health personnel other than physicians and dentists, and we support that.

Another Administration suggestion is that nursing students should seek to obtain loans under the Office of Education Basic Education Opportunity Grants (BEOG) Program. BEOG would not be an adequate substitute for financial assistance available under NTA. In the first place, even if fully funded, BEOG grants to nursing students would be about \$200 less than the relatively modest amounts they receive now. It is difficult to estimate the impact of hundreds or thousands of health students seeking aid from BEOG. Since it is an entitlement program, a large increase in the number of applicants can mean that individual awards may be reduced. NTA scholarships go to those with "exceptional financial need." Generally they go to students whom the school does not want to overburden with state loans or who cannot obtain state loans and who cannot obtain nursing school scholarships because they are underfunded or do not exist (nursing schools are traditionally under-endowed) -- in short, where alternate assistance is simply not available.

Without the assistance NTA provides and which BEOG is not equipped to provide, nursing education will be unaffordable for the neediest students. It is likely that the gains of NTA in dramatically increasing the enrollment of minority and poor students would be eradicated. In addition, the purpose of NTA is to assure the supply of nurses: who gets loans is controllable and traceable, so it can be evaluated as to whether the program is achieving its intended purpose. There is no way to maintain any such control under BEOGS. The NTA loan program also has proved effective and efficient. It

has a default rate of only about two per cent, compared to a rate under the OE direct student loan program ranging as high as 14-20 per cent.

Another indication of the Administration's lack of understanding of the importance of support for nursing education lies in the President's assertion in his veto message that "there is no reason for the government to provide special support to increase the total supply of professional nurses."

True, a purpose of NTA has been to assure an adequate supply of nurses to meet the country's needs for nursing care. But to talk only in terms of total supply is simplistic and ignores the variety of nursing functions, their expanding scope, the crucial role of nursing in the nation's changing health care system, and such trends as that for greater use of nurses in primary care.

Congress has not had the narrow Administration view of support to nursing education. It has recognized the need for support to advanced nursing education, to nursing research into improved methods of care and for the encouragement of nursing's efforts to provide health services in underserved areas.

One objective of the NTA is to help increase the number of nurses prepared at the graduate level to fill positions in nursing service administration and supervisor, research and education and gerontological and other clinical specialties. Despite the assistance that has been available, the number of nurses with advanced degrees is still far too low.

The WICHE Study Panel recommendations call for an increase above 1976 levels of 308 to 458 per cent prepared at the baccalaureate level, and 568 to 945 per cent prepared at the graduate level. In 1976, only 21 per cent

of nurses held baccalaureate or higher degrees. By 1982, the WICHE panel says, 64 to 66 per cent of registered nurses should have baccalaureate or higher degrees.

Just as medical and health care are increasingly complex, nursing is an increasingly complex field requiring extensive knowledge of both the physical and social sciences. Advances in biomedical research require well-qualified nurses to care for patients benefiting from new surgical and other new techniques of treatment.

Future requirements for nurses and other health personnel will be influenced by the form which national health insurance and/or other federal programs take. Increased coverage would seem the likely result of any national health insurance program as would expansion of health maintenance organizations. Health care costs are currently an issue of major concern, more and better use of registered nurses, we believe, can impact positively on this problem.

Another objective of the NTA is to improve distribution of registered nurses thus increasing health care available in underserved areas. For example, one option available to schools seeking to meet requirements for capitation grants is to provide for students to get a significant portion of their clinical training in community health centers, long-term care facilities and ambulatory care facilities geographically remote from the school. About 20 per cent of the schools participating in capitation conducted such programs in 1978. Many collegiate schools also have selected another option - to develop programs for the training of nurse practitioners who can work in underserved areas.

A change contained in the bill that was vetoed by the President and in the legislation before you now would limit loan forgiveness to those individuals who agree to serve as a nurse in a shortage area.

Numerous special projects funded under the Nurse Training Act also are directed at expanding the availability of nursing care. One project in Alabama was to prepare nurses for an expanded role in ambulatory care setting. Another was a training program to develop institutional nurse practitioners in Alaska. A special project in Arizona made a Central Arizona College practical nursing course available to native Americans in the Gila River Indian Community. In another special program, registered nurses were trained as neonatal nurse practitioners to provide service in outlying referral hospital nurseries and regional newborn intensive care centers. One special project was development of a program integrating knowledge of Navajo culture and history with the nursing component to fill the nursing needs of the Navajos on a reservation. In Florida a program for RNs to become geriatric nurse practitioners was organized and established with training centered on service in medically disadvantaged areas, and primary care of elderly people, and adults with chronic health problems.

Many of the recent advances in nursing stem from the U.S. Surgeon General's 1963 report, Toward Quality in Nursing--Needs and Goals, and as a result of federal investment in support of nursing, of advanced training of nurses, and in research and scientific investigations.

The WICHE panel projections now call for numerous changes including a marked shift in the percentage distribution by educational preparation of registered nurses. It estimates future need based on a number of variables - potential changes and developments in the health care system.

Congress last year noted the WICHE study and other investigations that were underway and voted a two-year extension of NTA in order to permit completion and evaluation of these reports. The measure before you now carries a provision that was in the vetoed bill requiring the Secretary of HEW to arrange for a study to review and evaluate such data that is now available in order to assess the program of federal support for nursing education, and to report to the Congress its findings and recommendations for legislation. The group recommended to conduct this study was the National Academy of Sciences.

In vetoing the Nurse Training Act extension, the Administration ignored its own commissioned study, the WICHE study. It also ignored the fact that Congress had provided for a review and evaluation of the current support program.

We hope that Congress will now get this issue back on track. We urge your speedy passage of this legislation.

American Nurses' Association, Inc.

2420 Pershing Road, Kansas City, Missouri 64108

(816) 474-5720

Barbara L. Nichols, M.S., R.N.
President

Myrtle K. Aydelotte, Ph.D., R.N., F.A.A.N.
Executive Director



Washington Office
1030 15th Street, N.W.
Washington, D.C. 20005
(202) 296-8010

RESPONSE TO HEN REPORT

1. A conclusion is made that cost containment measures will decrease and/or not increase the demand for nursing (Chapter 6, p. 90, 94, and p.i, cover statement).
 - a. This assumption is not addressed, supported, factored or documented as a condition leading to decreased utilization of registered nurses in any other part of the report.
 - b. There is no evidence which would support the assumption. On the contrary, cost containment efforts such as decreasing the number of acute care beds has increased the number of nursing hours per patient because bed turnover is now rapid and the patients are less capable of providing self care as their conditions are acute. With utilization review and short stays, patients require more discharge planning and teaching which are responsibilities of the nurse.
 - c. The last paragraph on p.i of the introductory cover statement is contradicted in the following paragraph on p.ii of the same statement. The assumption is made on p. i that cost containment would not lead to increased utilization of registered nurses. This assumption is then followed by a paragraph stating: "Pressures to control escalating costs of hospital care, furthermore, might encourage greater use of nursing homes, rehabilitation centers and convalescent care facilities where nurses are the primary providers of care and assume

ANA - An Equal Opportunity Employer

responsibility for its management over time." (p. 11).

2. The conclusion that the RN supply is adequate is based on "A National Health plan, when enacted will require a lead time of two to three years before initial implementation..."

- a. The enactment of National Health Insurance is but one of several changes in the health care system which might increase the demand for registered nurses.

- b. In identifying National Health Insurance as the sole Health System change affecting the demand for nursing services in Chapter 6, it appears the authors of this Chapter are negating the other major changes identified consistently throughout the report:

- (1) Vector Model demand factors (p.5)

- (a) Increased enrollment in HMOs
- (b) Reformulation of nursing roles

- (2) Systems Dynamics Model demand factors (p.21)

- (a) Changes in nursing education
- (b) Breadth of responsibilities (autonomy, complexity of tasks) of nurses
- (c) Staffing level per patient in hospitals
- (d) RN fraction of nursing personnel in hospitals
- (e) RNs required for ambulatory visits
- (f) RNs employed in community health and mental health center
- (g) Physicians in office-based practice
- (h) Hospital outpatient and ER visits
- (i) Nursing home beds
- (j) Staffing level in nursing homes
- (k) RN fraction of nursing personnel in nursing homes

- (l) Demand for nurses in public health agencies
- (m) Demand for nurses in occupational health
- (n) Demand for nurses in home care
- (o) Demand for private duty nurses
- (p) U.S. population

(3) WICHE STATE MODEL demand factors (p. 30)

- (a) Population
- (b) Health needs
- (c) Health goals
- (d) Health Services
- (e) Staffing patterns

c. If enactment of a National Health plan is envisioned three to five years from now (1982 to 1984) the supply of registered nurses, based on the projections in report, would not be adequate. The lead time indicated is not sufficient to warrant a decrease in supply or to substantiate the thesis that there is a balanced supply.

3. Another basis for concluding the adequacy of supply is that the cost-sharing provisions of a national health plan are likely to be greater than assumed in the models.

a. The extent of cost-sharing provision in a national health plan does not negate increased utilization of health services. In the report, only the Vector model addresses the issues of National Health Insurance financing mechanisms. While this can reasonably be perceived as a factor in utilization of health services, the emphasis in the Vector model

- is the implementation of a NHI system which would increase utilization of services (p. 5). In the other models, Systems Dynamics National Model and WICHE State Model, implementation of NHI system is one of several factors which would increase demand. The financing mechanism is not addressed.
- b. Again, a disproportionate emphasis has been placed on NHI over other factors.
4. The final basis for concluding adequacy of supply is that: "Substantial changes in nurse roles and responsibilities which would lead to significant increases in nurse requirements are also unlikely."
 - a. Chapter 6 does not offer any supporting data for this conclusion.

Indeed, there is no supporting data in the full report.
 - b. The Vector model concept of nursing role in Chapter 1, page 8, indicates that change in nursing roles is most likely to occur.
 - c. The Systems Dynamics approach examines the interrelationships of nursing education, nursing employment, demand and demography. In Chapter 1, p. 22 the baseline simulation, i.e. no changes, predicts a balance between supply and demand. However, when the simulation model incorporates increased nurse utilization and responsibility (i.e. autonomy; complexity of tasks) and increased RN staffing requirements in hospitals and nursing homes, etc., "the additional demand created by several trends toward intensive utilization of nurses and broader responsibilities is so great employment cannot keep up." (p. 25 Chapter 1).

5. In addition to the preceding, the title of Chapter 6 "Conclusions About Aggregate National Supply and Requirements" is questionable.

- (a) The title of Chapter 6 is not, as it suggests, the result of data analysis and subsequent conclusions. The only data presented are the projected statistics on supply. There is an absence of data and data analysis related to demand.
- (b) There is an absence of current data on factors affecting supply. In Chapter 7 the report indicates that "additional information on the supply, distribution of and requirements for nurses" will be forthcoming. Recent data has indicated changes in the projected supply of nurses:
 - Zero growth rate in schools of nursing
 - Numbers of newly licensed RNs are less than predicted
 - Changes in immigration procedures which will markedly decrease the number of foreign nurse graduates coming into the work force.
- (c) Chapter 6 does not discuss the documented need for nurses with advanced education, although this is mentioned in all major sections of the report. The projected supply of nurses with advanced preparation falls way below the projected need.

Mr. WAXMAN. Thank you.

On that point, I wonder if the experience of looking at ads in the newspapers, seeing so many of those advertisements, is unique to Texas and the District of Columbia?

Ms. HOLLERAN. No.

Mr. WAXMAN. Where would you find that in other places?

Ms. HOLLERAN. We find that all around. When they use the word "registered nurse," that is a licensed professional nurse. If they just use the word "nurse," without a definition, in the District of Columbia, you cannot be sure.

Ms. HAUER. I would also like to respond to that. If you will pick up the New York Times on any Sunday, you will find over 50 ads in there for major hospitals, small hospitals trying to recruit nurses. You will also find staff builders coming from California, coming from the Midwest, from Texas, trying to recruit people from New York to go out there because there is such a tremendous shortage, trying to lure them, knowing there is still a shortage in New York, trying to get them out there where they feel perhaps the West Coast going down to Texas and so forth really has a shortage.

Any New York Sunday Times will give you a terrific picture of what the shortage is in all the major hospitals. Despite a shrinking of the hospital system as Dr. Foley talked about, and in spite of hospitals being closed in New York State, there is still a tremendous shortage of nurses.

You need nurses. If they are not in the hospital, the patients, they are in the clinics and you need nurses taking care of those patients plus in the whole health care delivery system.

Ms. LOHR. At the University of Michigan Hospital, we have three full time recruiters that bring nurses into that facility. Three persons who recruit nurses for that one facility year round.

Mr. WAXMAN. It sounds to me that you are saying we have a shortage of nurses everywhere, and it is an aggravated situation in the less desirable places for nurses to work.

Ms. HAUER. I think Mr. Gramm made an excellent point when he talked about geographical distribution, nurses are going to stay where there is money, where they are getting well paid, where they are going to work in medical centers, where there is equipment and so forth, if there were no job vacancies there, they would have to move on. The vacancies are there and they can employ them in the hospitals in the major large cities. There is no point in going to the smaller areas. The jobs are there for them.

Mr. WAXMAN. Why is it, if there is a shortage, the wages that hospitals are willing to pay for nurses are still so low?

Ms. HAUER. I will only speak for New York. I think in the past 5 years, since 1972, wages in New York City are comparable to other professions. I cannot speak for other areas. I think if you just go to New Jersey, the salaries are much lower. I think they have come a long way but they are still not meeting the salaries in comparison to other places.

I think New York, Chicago and California have better salaries.

Mr. WAXMAN. Thank you. Dr. Carter?

Mr. CARTER. Thank you, Mr. Chairman.

I have certainly enjoyed the presentations of each of you here this morning.

From what I see, there certainly is a lack of a sufficient number of nurses clearly shown in the statements you have given. It is admitted by HEW in its own report that in 1977, there were 854,000 employed nurses. At the same time, by 1985, we will need between 1.2 million and 1.3 million nurses. Yet because of the recision we are cutting the program by \$15.75 million this year.

HEW says they are going to use the National Health Service Corps to support nursing students. Yet, the amount of money that would be added by HEW to that particular program is really miniscule. It will not nearly cover the amount of money necessary to support the students who will need financial assistance if the current laws loan and scholarship programs are terminated.

Do you expect nursing roles and responsibilities to change significantly in the coming years in a way that will influence the demand for nurses?

Ms. LOHR. Yes, indeed. I think nurses will become increasingly involved in teaching and aim toward prevention of illness and maintenance of health at an optimum level. I think this will serve to augment and accelerate the need for additional nurses.

I think nurses will become more involved in working with patients at the community level, going into the homes and doing health teaching and actually caring for the sick and the infirmed at homes.

I think nurses will be attending to a greater extent to the care of the aged persons in nursing homes, too. I think these are other underserved populations.

Mr. CARTER. Yes, ma'am. The administration's recent report on nursing supply state that significant increases in the utilization of nurses are highly unlikely in the face of current and future cost containment efforts.

Would you want to comment on that?

Ms. HOLLERAN. I think they also, in that report, make reference to the fact that they anticipate because of the pressure to get patients out of the hospitals more quickly that you will find more patients in rehabilitation centers and requiring home care. Their report is very inconsistent, in that regard, Dr. Carter, in my opinion.

Mr. CARTER. How will we take care of patients in burn units, for instance, in which we will need specially trained nurses, or coronary care units or intensive care units, unless we have a clinically trained nurse for these positions?

We know there has been an explosion in technology. We must have highly trained people.

Why do you think the HEW does not want to fund training for nurse anesthetists?

Ms. HOLLERAN. I am not sure that they do not want nurse anesthetists.

Mr. CARTER. They have not supported such funding, have they?

Ms. HOLLERAN. No, they have not. They have not supported the extension of that program either.

I think it is as Congresswoman Mikulski says, OMB is really the group that is calling the shots on what HEW can or cannot publicly support.

Mr. CARTER. I think you are right on that, too.

What category of nurses do you feel is the greatest in demand and the most undersupplied at the present time?

Ms. HAUER. I would like to qualify that and answer in two ways. I think in terms of the shortest supply, I think first we should talk about the bedside nurse. I think we have a short supply as evidenced by all the ads where you need medical-surgical nurses, operating room nurses, nurses in critical care units.

I think we also have to look at the fact that we have a short supply in the number of teaching faculty. Over 800 vacancies occur in colleges across the country for faculty in schools of nursing.

As for prepared administrators for hospitals in terms of nursing administrators, there is a tremendous shortage.

We really need funds for educating nurses at a higher level and also at the entry level.

I would like to say even though PSRO has reduced the length of stay from say 11 days in the hospital to 10, the fact that you have critically ill patients because of the short turnover, you need better prepared nurses in your critical care units. You have sicker patients who are coming into the institution. You still need a larger number of nurses even though we are condensing or shortening the length of stay.

Mr. CARTER. What considerations are important to a nurse in deciding whether to practice in a medically underserved area and how can we entice nurses to these medically underserved areas?

Ms. HOLLERAN. Dr. Carter, one of the problems that has not really been addressed by the administration in this regard is nurses in general are employees of an institution or agency. As a result, our third party reimbursement system is not tuned in to reimburse nursing services. Unless there is a place for a nurse to work in an rural area, she cannot survive; unless there is a clinic, a small hospital, there is no place for her to practice.

It is kind of unfair to say she will not go there, when this is one of the inhibiting factors.

The rural clinics' bill which was approved last year by the Congress should help somewhat to make it possible for nurses to be employed in those underserved areas.

Mr. CARTER. It has helped some. Thank you very kindly.

Mr. WAXMAN. Mr. Preyer?

Mr. PREYER. Thank you. I think you have made some excellent points. I just have one question.

Ms. Holleran, you mentioned the OMB report which you just received last week. Would that be the OMB/HEW report on the shortages?

Ms. HOLLERAN. It is the second report to the Congress which was required by the Nurse Training Act of 1975 which should have been submitted to you on February 1, 1978. It was delivered to Senator Kennedy's Committee at 6:30 p.m. last Thursday night before the 10 a.m. hearing the next day.

[See p.—]

We have tried to do a quick critique for the record.

Mr. PREYER. Is this the report that Dr. Foley was relying on?

Ms. HOLLERAN. Yes, it is.

Mr. PREYER. Can you give us a critique on that for the record?

Ms. HOLLERAN. Yes, I will.

[The following information was received for the record:]

ANA CRITIQUE TO CHAPTER 6 OF SECOND REPORT TO CONGRESS

Mr. Chairman, we have submitted a statement for the Record. I would just like to add a brief critique of parts of the HEW's Second Report to Congress on the Nurse Training Act which was released late last week.

Presumably HEW's position on this issue is largely influenced by that report, and we regret that it was not available earlier. It was due February 1, of last year. This is the first opportunity that Congress has had and the first opportunity that we have had to examine that report.

It draws certain conclusions about "aggregate national supply and requirements" for nurses. It reviews studies or "aggregate modeling efforts." These studies make various projections of need depending on whether there will be no health system changes, minor changes, moderate changes or liberal changes. Another aspect of the study makes moderate estimates and liberal estimates of need.

The HEW report reviews all these possibilities which are presented, comes up with what it terms the "most likely case" and concludes that "the aggregate national requirement and supply for 1985 will be in balance." This conclusion does not appear to be consistent with the report as a whole.

We cannot agree that nursing supply will continue to expand at a rate to keep even with need without continuation of federal assistance for the following reasons:

- National League for Nursing figures show a zero growth rate in nursing school admissions and graduations even with current levels of federal support.
- Numbers of newly licensed nurses are less than predicted.

- Changes in immigration procedures to assure that foreign trained nurses meet licensing requirements will decrease the numbers of foreign nurse graduates entering the country.

When we discuss federal support, we are talking about maintaining supply even with current funding. We are not talking about sustained growth in such funding.

I cannot go into detail in the time we have today, but I would just like to look at a few of the assumptions on which the conclusions of the HEW report are based:

- Cost containment measures will decrease and/or not increase the demand for nursing. This assumption is not supported or documented in the report. There is no evidence to support the assumption. On the contrary, cost containment efforts such as decreasing the number of short stay hospital beds has increased the number of nursing hours per patient because patients are sicker while hospitalized and turnover is rapid. With utilization review and short stays, patients also require more discharge planning and intensive patient teaching which are responsibilities of the nurse.

The report also contradicts its own assumption by stating that "pressures to control escalating costs of hospital care, furthermore, might encourage greater use of nursing homes, rehabilitation centers and convalescent care facilities where nurses are the primary providers of care and assume responsibility for its management over time." (p.ii)

- A national health plan, when enacted, will require a lead time of two to three years...and additional coverage and benefits are likely to have a phase in period.

There is no indication that there is any provision for this eventuality, however, whatever the lead time. The lead time indicated is not sufficient to

warrant dismantling the present system of federal support leading to the leveling out or decrease in the supply of registered nurses.

- It states substantial changes in nurse roles and responsibilities which would lead to significant increases in nurse requirements are also unlikely. Yet there is no data in the report to support this contention. In fact, the Vector report, one of those used by HEW in reaching its conclusions, states that there is little likelihood of nursing roles remaining unchanged.

Another of the studies used by HEW, the Pugh Roberts Report, using a "base-line simulation" i.e., no changes in the health system, predicts a balance between supply and demand. However, when the simulation model incorporates increased nurse utilization and responsibility (e.g. autonomy, complexity of tasks) and increased RN staffing requirements in hospitals and nursing homes, etc. the report states "the additional demand created by several trends toward intensive utilization of nurses and broader responsibilities is so great employment cannot keep up." (Chapter 1, p. 25)

There is no reference in the report's conclusions to the documented need for nurses with advanced education, although this is mentioned in all major sections of the report. The projected supply of nurses with advanced preparation for clinical practice and for management and teaching positions falls far below the projected need.

We recognize that it is quite possible to come to different conclusions based on data contained in the studies which HEW used for its report. The studies themselves project various alternative possibilities but do not draw conclusions. It seems to us that the HEW report, in effect, cops out, takes a gamble that the health care situation will remain static. Its Chapter 6 seems out of sync with the rest of the report.

We disagree with the conclusions. We also believe that the data presented and the HEW report demonstrate that the Congress has been on the right track all along. It points clearly to the need for a review and evaluation by a truly objective free outside group to determine the need to continue, revise or eliminate a specific program of support to nursing education. Such a study by the National Academy of Sciences was called for in the bill passed by the Congress last year and vetoed by the President. That study is called for in the legislation before you now. This is the course that we and the other groups have endorsed.

The President by his veto has interrupted an orderly process. We think this is shortsighted and could well end up costing the U.S. taxpayer a great deal more in the long run.

Speaking as a nurse, I am well aware that the American public is entitled to a higher quality of nursing care than is now possible in many of our city hospitals, nursing homes and rural areas. We need your help to provide the resources necessary to deliver that quality care.

We hope the Congress will now act to get this issue back on course.

Connie Holleran
Director, Government Relations Division
American Nurses' Association

Mr. PREYER. Thank you very much.

Mr. WAXMAN. Ms. Mikulski?

Ms. MIKULSKI. Thank you, Mr. Chairman.

It gives me a great deal of personal pleasure to welcome such a distinguished panel of female healers.

Mr. Chairman, I just want to respond, when they talked about why women are not going to underserved areas, I think Connie answered that to a certain extent but the other problem is that nursing is an unique opportunity in this country for women to combine both a career and a married family life.

I know the women in my community, for many of them, that was one of the ways they could have a combined career and it was both culturally acceptable and pragmatic in terms of time and availability.

Very often where the greatest need is perhaps for the nurse, there is no job opportunities for her husband because we are talking about usually communities that have terrible unemployment problems. They are the small towns facing structural unemployment problems and whatever.

I think that is part of it. Second, by the very nature of that economy, they are not able to support the kinds of institutions at a financial level that would be able to offer some opportunities.

It was what I was trying to get across to Mr. Foley that these things interlock and interact and you cannot have a simplistic solution.

Moving along with my questions or comments, one, I just want to share with you a role for a nurse. There is no doubt that it is an expanding role. I think the past decade indicates this and when I first got out of graduate school in social work in the 1960's compared to what it is now, it is dramatically different.

The head of our Democratic party in Maryland and the majority leader of our State senate in Maryland is a nurse, Senator Rosalie Abrams, a graduate of Sinai Hospital. In her role both as a political leader and because of her background in health, she has been able to play a major substantive role in health care.

Moving on to my question, HEW offers one set of alternatives to deal with nurses. This committee, I think, is looking for other ways of serving it. Perhaps the old way of scholarships and training where someone has not met the need. I just wonder what concrete suggestions you would have legislatively and none of us like what HEW had to offer and yet I am wondering what other suggestions you could offer from a legislative standpoint in terms of either targeting or fiscal levels to be able to meet the needs, the shortages you outlined but also pay particular attention to the underserved communities that we are really worried about.

Ms. HOLLERAN. Perhaps I can respond, and point out the proposed study that is part of the legislation that you are considering today is one that we fully support. We think it is an outside objective group that could be making some long term recommendations for changes and revisions in Federal support for nursing education.

We all know there needs to be some changes. We are hoping that study can be started fairly soon.

Ms. MIKULSKI. Which study?

Ms. HOLLERAN. This is a study that is a proposal within the Nurse Training Act which was vetoed last year and it is in this bill that there be a study by the Academy of Sciences or some such group to make recommendations to the Committee.

You made reference earlier in this session to having a payback requirement for assistance to nursing students. The ANA supported that kind of a tie in when the legislation was being discussed in 1975. We objected to having students have to pay back time because the school got money. We did support the idea that if the student directly got money and there was a reasonable way for them to make a commitment to work in a certain field that was appropriate.

We did not think the student should have to pay back for the school funds.

We are open. We are willing to make changes if there need to be changes and we would hope to work through the next year as the study progresses and with the Congress so when this 1-year bill or 2-year bill is completed, we should be really ready for something major.

Ms. MIKULSKI. Would you concur that when we talk about funding of nursing priorities, that we set a minimum, that we guarantee over a long term, say a 3- to 5-year authorization, so we can do the kind of recruiting, so people know back in high school that they can start planning their curriculum, et cetera?

Ms. HOLLERAN. It would certainly be helpful.

The initial Nurse Training Act of 1964 was a 5-year proposal and then the following year or the next time around it was 3 years. We have been on continuing resolution for awhile now.

Ms. HAUER. I think your point was very well taken where you said recruitment occurs at the age of 14 and not at 17.

Also the disadvantaged student who sees that headline, funds cut for nursing, is not going to go into nursing. I think that was an excellent point that you made that we have to focus in on this group and they have to know that the funds are available.

Ms. MIKULSKI. Even sadder, not only will they not go into nursing, they will not go into anything else. As you all know from your work, unless you know that you have a future, they are more likely to end up as being served by a teenage program rather than being the nurse in the program.

Ms. LOHR. We need to look very carefully at the data base that we use to make decisions regarding support for nursing.

I think the administration needs to have a very careful comprehensive data base so we can all feel comfortable with and we need to know the assumptions from which the data were derived or used to derive the data.

Ms. MIKULSKI. No, Doctor, I am going to disagree with you on that. Those decisions were not based because of inadequate data. There are lots of reasons and they were purely political. They read the same numbers you do and I would like to associate myself with my colleague, Mr. Gramm, when he said 1 minute we had a nursing shortage and the next day it was all gone.

It has not changed. Politics of the situation have changed and they went after a constituency that is primarily women or scholarships that serve primarily the poor in which they felt there would

be no outcry. I wish they would exercise the same type of vigor when it comes to gas pricing or other things in this country.

Ms. LOHR. I understand that point.

Ms. MIKULSKI. I think if the nurses pulled an 1-day strike and yet covered patient care in this country, they would know what the real scoop is.

We had a blizzard in Baltimore. Nobody missed the politicians. Nobody missed the coordinators. Nobody missed the fact that OMB could not get in from Montgomery County. This town and my town could not function because the nurses were stranded. The ones that did work were working 16 and 18 hours, staying overnight and working.

Ms. LOHR. That would be one source of data. That would be one way of getting some useful data.

Ms. MIKULSKI. I am ready to be more militant.

Thank you, Mr. Chairman. I am finished.

Mr. WAXMAN. Thank you, Mr. Gramm?

Mr. GRAMM. Thank you, Mr. Chairman.

I would like to simply point out that my mom is a nurse. She told me three things about nurses. One, you ought to listen to what they have to say; two, you ought to believe everything they tell you; and three, you should carry out all of their instructions. You have a ready and eager audience in me.

I co-sponsored with the distinguished chairman of our full committee, H.R. 1143. I believe we have an excellent opportunity in this bill to override the mandate of the President, HEW or OMB, depending on where you want to point the finger.

Since I basically agree with everything you are saying, I would like to use the brief moments I have to alert you to a concern I have.

I am not sure whether OMB is calling the shots or whether HEW is calling the shots. I think it is a combination of the two.

I think we have an effort on the part of the Federal Government to sell federalization in America's medical market to the American people. As has always been true, whether we are selling defense spending or whether we are selling collectivization of a market, the method that is used by Republican or Democratic administrations is always to make the people think they are going to get something for nothing.

I believe that what is happening in HEW is we are seeing a concerted move toward convincing the American people that hospital costs have been rising, to quote the President, "because hospitals are greedy." That is a peculiar kind of charge when 91.8 percent of the hospital beds are in non-profit institutions.

You can get away with those kind of assertions against Exxon but when you are talking about hospital administrators in my community, you are talking about a nun. She may be many things but greedy is not one of them.

What is happening is that the American people are being sold an idea by the administration that we can control hospital costs but the way we are going to control it is through controls.

When the Secretary of HEW, Mr. Califano, came before our committee in a joint hearing with Ways and Means, Mr. Califano made a continual reference to the fact that problems such as

malpractice insurance, were going to disappear under national health insurance.

I would like to just solicit your help and your concern in this area where I see Federal encroachment into the hospital market.

We have a problem in the medical care delivery system. I do not think anybody is going to deny that. I think it is important that we remember the existence of a problem does not in itself call for a Federal program.

Secretary Califano points out the fact we have over 90 percent of the people using medical care covered by third-party payers and they do not have the same incentive to economize.

My maid back home takes her children to the emergency room with the flu, primarily because the Government is paying. I do not take my children to the doctor with the flu because I figure they will get well whether they go to the doctor or not.

The point I am trying to make is this; the whole idea of hospital cost containment and the whole idea of national health insurance is being sold on the idea that there are these greedy and inefficient, corrupt people delivering medical care services, and by controlling them, we can hold down costs and in the process, get something for nothing.

I have a concern that the demand for medical care is virtually insatiable. If we are going to allow people to consume it without having to pay for it, we are going to have to produce massive amounts of it.

I simply would like to use my time, Mr. Chairman, in soliciting your help in obtaining the facts about hospital cost containment and the facts about national health insurance as it is being proposed by this administration and I am sure it will be proposed by the next.

Using the credibility that nurses have, and in trying to get the facts to the American people today, I would solicit your help.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Gramm.

Thank you very much for your testimony and the information you have given us. It will be very helpful to us as we deal with this legislation and helpful to evaluate the proposal that the administration has presented to us.

I would like to now call Joyce Kelly, Director at Kaiser-Permanente School of Anesthesia in Los Angeles, Calif.

Ms. MIKULSKI. A witness from Los Angeles, that is surprising.

Mr. WAXMAN. We have problems we want you to know about.

Ms. MIKULSKI. Yesterday was Baltimore Day.

STATEMENT OF JOYCE KELLY, C.R.N.A., ON BEHALF OF AMERICAN ASSOCIATION OF NURSE ANESTHETISTS

Ms. KELLY. Mr. Chairman and members of the Committee, I am certainly happy to be here today to give you a view of some of the problems that we have as nurse anesthetists.

I am Joyce Kelly. I am a certified registered nurse anesthetist. I am presently the director of the Kaiser-Permanente School of Anesthesia for nurses in Los Angeles and also an on-site senior visitor for Accreditation of Schools of Nurse Anesthesia.

I certainly want to support my colleagues that were here just before me as far as the need of the bills that are presently being presented and I also want to thank the members of this panel that have been supportive of different bills. We certainly do feel the nurse anesthetist needs to be included in the bills.

As far as figures go, the figures that have been given this morning are certainly not supportive of nursing and their needs. HEW did do a study called "Supply, Need and Distribution of Anesthetologists and Nurse Anesthetists" in 1976, which projected the number of nurse anesthetists needed by 1980 to be of 22,000 to 25,000. We have presently 15,000 nurse anesthetists.

At the same time, we have had a decrease in the total number of schools of nurse anesthesia here in the United States. At the time the survey was taken, there were 225 schools. At the present time there are only 165 schools.

The nurse anesthetist training programs are a post nursing program and they result in a certification. The programs do last 24 months consecutively and they are intensively involved in chemistry, pharmacology, anatomy, and physiology and a preceptorship in the clinical area.

The educational programs are in a hospital setting. The costs of the programs such as teachers, salaries, and supplies are generally absorbed by the hospital itself.

The major financial burden of these programs to date has been the support of the traineeships or the stipend that the student receives. The average stipend is around \$3,000 and as you all know, the cost of living is at least from \$5,000 to \$6,000 a year.

We have two problems that arrive here as far as the costs are concerned. No. 1, the students have great difficulty in meeting the costs of living and education, so they therefore do not go into the field. No. 2, the programs that do have stipends for the students cannot increase their programs because of the cost of the stipends.

We also have another factor. The financial disadvantaged student who does not have the money in the first place, does not get the opportunity to continue in the educational process advancing to the education for the nurse anesthetist.

There is certainly a shortage which is shown by the HEW report. One of the reasons we started our school at Kaiser was evident after I was appointed to do a survey as to the possible reason for a shortage of nurse anesthetist personnel in our area. There were nurse anesthetists to be found and I was asked to do a feasibility study to start a school. That is one of the reasons why we have our school. There simply were no nurse anesthetists available for Kaiser to hire.

I recently made a visit to Kentucky as an on-site visit or for accreditation of an anesthesia program. Harlan, Ky., where the only school in the State is located and certainly in a very depressed area, was found to be in great financial difficulty and certainly in need of money to subsist on.

As far as the anesthesia care in the United States, 50 percent of the anesthesia is provided by nurse anesthetists.

In the hospitals of 100 beds and less, 68 percent is given by nurse anesthetists.

As you see the decrease in the number of nurse anesthetists in the United States you will see that either the surgery is not performed or it is performed by people who are not really adequately prepared. Or, we could go to a system with only anesthesiologists giving all the anesthesia services which would represent a great increase in cost to the patient.

It would be nice to go to a system where we have anesthesiologists who do consult with several nurse anesthetists and this certainly would be a more efficient and economic way to provide anesthesia services.

I have submitted to each of you and for the record my testimony. I would like to take this time so you will be able to ask me questions if there are questions you would like to ask.

[Testimony resumes on p. 115.]

[Ms. Kelly's prepared statement follows:]

STATEMENT OF JOYCE KELLY

The American Association of Nurse Anesthetists ("AANA") is a professional organization whose membership is comprised of Certified Registered Nurse Anesthetists ("CRNAs"). There are presently 15,000 active practicing CRNAs in the United States. Each one of these individuals holds unique qualifications which allow them to administer anesthesia. AANA submits that in the absence of an anesthesiologist, or a physician anesthetist with a significant background in anesthesia, that the CRNA possesses the necessary knowledge, skill and educational background to be involved in the assessment, management and administration of a patient's anesthesia requirements under the medical direction of a responsible physician. For individuals to represent themselves to the public as CRNAs, they must hold a current license as a registered professional nurse, have graduated from an accredited program of nurse anesthesia, have passed a rigid qualifying examination, and must be involved in a program of continuing education in anesthesia.

We would like to take this opportunity to indicate our strong desire that the Nurse Training Act authority be extended and at authorization levels sufficient for program growth. We were generally very distressed that last year's legislation was vetoed and we would hope that a bill quite similar to last year's bill would be passed by Congress. We are generally supportive of the American Nurses Association ("ANA") in its efforts and positions on this legislation. We worked to restore funds cut in recent proposed rescissions and we want to commend members of this Subcommittee for their efforts to this end.

We are also particularly interested in the passage of a bill which includes the traineeship program for nurse anesthetists. Various bills introduced by members of the House Subcommittee include such a provision and we thank those members sponsoring or co-sponsoring such bills. We are distressed that S. 230 contains no such provision and hope that the Senate will eventually pass a bill with such a provision in it.

We would now like to address ourselves to the provisions relating to nurse anesthetist training.

1. The Educational Program and Training of a Nurse Anesthetist

As this testimony will point out, the CRNA is a much needed element within the health care system. To understand the type of educational program the CRNA must complete (and the type of program for which we are requesting Federal support), allow me to delineate the current educational requirements for CRNAs. Building on the professional nursing base, the student nurse anesthetist must complete the following program:

Orientation to Anesthesia Practice - 45 contact hours; Chemistry and Physics of Anesthesia - 45 contact hours; Advanced Anatomy, Physiology and Pathophysiology - 120 contact hours; Principles of Anesthetic Management - 60 contact hours; Pharmacology of Anesthetic, Adjunctive and Ancillary Drugs - 60 contact hours; and Clinical Correlative Conferences - 35 contact hours. Also included in the clinical program is a requirement of a minimum of 600 hours of actual anesthesia time in which clinical instruction is provided in situations where students actually administer the anesthesia. Other requirements include a minimum

of 450 cases of anesthesia actually administered with these cases distributed according to types of techniques required and variety of drugs used. With this type of background, there should be no doubt as to the ability of the CRNA to provide the patient with quality anesthesia care.

Training programs are graduate-level programs for registered nurses. Training involves 18 to 24 consecutive months of course work and clinical instruction and a certificate of graduation is received when the program is successfully completed. All training programs are accredited by an accreditation body approved by the Office of Education. There are presently 165 of such programs while there were 225.

2. The Dimensions of Nurse Anesthetist Practice

As previously stated, the CRNA is a vital element within the health care system in the United States. Nationwide, nurse anesthetists are providing safe, reliable and economic anesthesia care to approximately one-half of all of the patients undergoing anesthesia. Included in this statistic is the fact that in rural areas nurse anesthetists account for approximately two-thirds of all anesthesia care rendered. Throughout many areas in the country, nurse anesthetists are the only providers of anesthesia care. (In a 1971 survey of hospitals, forty percent of all of the hospitals surveyed had only nurse anesthetists on the staff.) According to figures published in the February, 1978 issue of Anesthesiology, the national mean population ratio for active practicing nurse anesthetists is 7.20 per 100,000. This figure compares with a distribution of 4.64 anesthesiologists per 100,000. A break-

down of these figures on a regional basis will show that the areas with the thinnest distribution of anesthesiologists have the highest distribution patterns for nurse anesthetists.

3. Supply and Need for Nurse Anesthetists

Not only are CRNAs a vital segment of the health care system within the United States, there is a definite projected need for more nurse anesthetists in the future. According to a 1976 study by the H.E.W. Bureau of Health Manpower on "Supply, Need and Distribution of Anesthesiologists and Nurse Anesthetists in the United States, 1972 and 1980" (HRA:77-31), there is a projected need of from 22,000 to 25,000 nurse anesthetists for 1980. Obviously, there is a serious shortage in this field which provides approximately half of all anesthesia services in the United States. Inclusion of the traineeships for students in schools of nurse anesthesia in the Nurse Training Amendments of 1979 will be the first step on the part of the Federal Government to rectify this shortage.

The fact that nurse anesthetists are a significant group in the delivering of anesthesia services was pointed out by Dr. Feldstein of the University of Michigan in a study of the 16,500,000 surgical procedures performed in 1974. The largest percentage of anesthetics administered, 48.5%, was rendered by CRNAs; 38.3% was rendered by anesthesiologists, including both board-certified and non-board-certified; 9.7% by physicians other than anesthesiologists; and 3.5% by registered nurses other than CRNAs. A further breakdown of those procedures indicates that certified registered anesthetists administered approximately two-thirds of all the anesthesia procedures in

hospitals smaller than 100 beds. Anesthesiologists tend to congregate in larger hospitals, over 200 beds, where they administered 47.5% of all anesthesia compared to 42.5% for Certified Registered Nurse Anesthetists.

4. Economics of Nurse Anesthetist Services

The majority of nurse anesthetists are salaried hospital staff, whose services are billed by the hospital as part of hospital operating room costs. According to the U.S. Department of Labor, Bureau of Labor Statistics, "Industry Wage Survey of Hospitals, August, 1975 - January, 1976", the average hourly wage for nurse anesthetists working in 21 major metropolitan areas was \$8.02. Based on a 40-hour work week, the average annual earnings for a nurse anesthetist would be \$16,681.60. This figure compares with full-time equivalency earnings of hospital-based anesthesiologists of \$80,000 as determined by a Health Care Financing Administration "Study of the Reimbursement and Practice Arrangements of Provider-Based Physicians, December, 1977" (Contract No. 600-76-0055). An analysis of these two salary figures indicates that where nurse anesthetists are providing anesthesia services, the cost to the patient should be substantially lower than where anesthesiologists are providing the services. Even where a team approach is used, the fact that some of the time utilized is of CRNAs rather than anesthesiologists would indicate efficiency and cost savings.

5. Need for Federal Training Support

Nurse anesthetists are clearly a shortage field in health care. Possibly twice as many nurse anesthetists are needed

for 1980 as are practicing now according to the HEW study cited above.

One of the obstacles to obtaining them is the lack of financial support for trainees. Training programs are generally for two years; a substantial graduate program. A survey of all educational entities providing these programs indicates that the average monthly stipend from the school is only \$259 or about \$3,000 per year. (Stipends for research careers are, for example, \$10,000 to \$13,000.) The total of tuition and all costs is, at a minimum, \$5,000 to \$6,000 per year to the student; presenting a deficit of \$2,000 to \$3,000. Students are generally unable to hold part-time jobs because the nurse anesthesia program runs for 18 to 24 consecutive months. In addition, rotating clinical schedules prevent part-time work in the evenings and on weekends. The financial problems mentioned above deter students from entering this field. Loans are difficult to obtain and entry level salaries are in the \$15,000 range with average salaries after 5 years at \$20,000. Such salary levels are not conducive to borrowing particularly if an individual has a family to support.

Traineeship support authorized at \$2 million and \$3 million in the first two years would assist in meeting the average \$2,000 a year or more financial deficit of students. About 1500 students a year could benefit at the rate of about an additional \$150 a month stipend from such a program. \$150 a month was the average deficit in 1977 of these students, relative to their living needs.

To the institution, the major financial burden is in

making stipends available to students. With living costs what they are and no time for part-time work, stipends are critical. Institutions put up \$3,000 on the average toward these living and educational costs of \$5,000 to \$6,000. Limited resources prevent institutions from offering more aid or from offering aid to more students. Federal support to the institutions for traineeships will allow a greater number of students to enter programs since some programs are prevented from expending due to the lack of stipend money. It will also relieve the burden on low income students to permit their entry into the program. In addition, with the Federal Government picking up some of the traineeship costs, institutions will be able to devote some of their future funding to program expansion.

It should be noted that the number of nurse anesthetist training programs has decreased by about 60. These were the smaller programs. Federal support may prevent such harmful attrition and stimulate the development of new programs.

With respect to operating costs of nurse anesthetist training programs, patient care hospital revenues support such activity as staff, supplies and teaching space. We note with satisfaction, that such costs of hospitals are excluded from the recent hospital cost containment legislation offered by Senators Talmadge and Dole.

We appreciate the opportunity to testify and your Subcommittee's attention to this matter.

Mr. WAXMAN. Thank you. How many applicants do you have for each vacancy in the school?

Ms. KELLY. We have about 300.

Mr. WAXMAN. Of those students who are applying to become nurse anesthetists, how many can afford to pay for their tuition and living costs?

Ms. KELLY. I would say every student needs outside support financially. Remember, they cannot work because of the clinical preceptorship that they have. They work a 40-hour week with classes. It is impossible for them to work on weekends and really turn out to be any kind of student in the end.

They either have to have family support or outside support, and this is where the real problem is for some students. As you know, the middle- and lower-income people are the people who go into nursing. These people do not have funds, so therefore they cannot come into the system.

Mr. WAXMAN. The schools provide stipends for students; is that correct?

Ms. KELLY. That is correct.

Mr. WAXMAN. The money that would be provided for under the Nurse Training Act would be in addition to the stipends?

Ms. KELLY. Correct. The stipend they get is about \$3,000 a year and some of them not even that much. I think stipends range from about \$100 a month to \$500 a month. The ones getting \$100 a month certainly cannot live on \$100 a month.

Mr. WAXMAN. Mr. Preyer?

Mr. PREYER. I just want to thank you for your testimony and for pointing out the problem areas with which I was not familiar. I was not aware of the extensive role a nurse anesthetist plays in giving anesthesia.

Did you say 58 percent?

Ms. KELLY. Sixty-eight in the small hospital. These are in the areas in which we talk about the maldistribution, in the small hospital in the community out in the boondocks, per se, where the nurse anesthetists are providing the sole service.

Mr. PREYER. Thank you very much for your testimony.

Mr. WAXMAN. Ms. Mikulski?

Ms. MIKULSKI. Thank you, Mr. Chairman.

I just want to clarify a question that you asked when you said how many students apply for each vacancy. You said, Ms. Kelly, 300 per vacancy?

Ms. KELLY. We have eight students that we admit each year. We have about 300 people inquire by letter.

Ms. MIKULSKI. What happens to the other 292?

Ms. KELLY. They try to go someplace else. As I say, there were 225 schools and there are now 165. We have people that have been trying to get into school for 5 years.

Ms. MIKULSKI. These are people who already have their nursing training?

Ms. KELLY. Yes. They are already RN's.

Ms. MIKULSKI. This is a special program or post?

Ms. KELLY. This is a specialty post-nursing.

Ms. MIKULSKI. We are now down to 165 schools.

How much does a person with the proper certifications earn? What is the average earning?

Ms. KELLY. You mean upon graduation?

Ms. MIKULSKI. Yes.

Ms. KELLY. I believe the statistics show about \$16,000. Within the first 5 years, it is generally up to \$20,000.

Ms. MIKULSKI. The salary range is pretty much \$16,000 to \$20,000?

Ms. KELLY. Yes, to start out.

Ms. MIKULSKI. Perhaps in some other areas it could go a little bit higher?

Ms. KELLY. Yes.

Ms. MIKULSKI. It is certainly a very different salary scale when we think of an anesthesiologist.

Ms. KELLY. They are starting at around \$80,000.

Ms. MIKULSKI. There is no cap, I see.

Ms. KELLY. There is no money for these students. Since we are hospital based, we cannot get the funds that regular nursing students can. Being hospital based, most of the programs do not give a degree when they graduate, so therefore there are no Federal moneys available to them.

Ms. MIKULSKI. I think you have brought a rather important thing to our awareness when you said the students cannot work on weekends. It seems to me that this is the unique situation of a poor student who chooses health as a career.

My sister is studying X-ray technology.

Most students who are scholarship kids, went to a community college to be computer operators or whatever, can work after school and on weekends in a supermarket or a gas station, picking up a few extra bucks to tide them over if their family is poor or near poor.

Students in allied health fields by the very nature are actually delivering service while they are learning, and they are precluded from part time jobs. That would be true in nursing and others.

A certain kind of aid is even more important to them. Am I on the right track?

Ms. KELLY. Yes, you are exactly right. They have a receptorship, a traineeship, which is the same as a residency program. They are in the clinical area when they are not in the classroom.

If they have any time to study at all, it is on the weekend. Most of our students spend from 20 to 30 hours a week studying on top of the 40-hour week which includes the class.

Ms. MIKULSKI. Thank you very much.

Thank you, Mr. Chairman.

Mr. WAXMAN. Mr. Gramm?

Mr. GRAMM. In your area of expertise, we have a clearcut situation where we would have an opportunity to strike the cost of medical care at its very root by expanding our expenditure in your area to expand the number of people who are qualified to perform specific services. In those services and in some cases under the supervision of an anesthesiologist, we can displace people who are very expensive to train and to put on the job with people who can provide quality care of specific types at a lower cost.

Would you agree with me that if we were really trying to attack the problem from a supply side, instead of from this demand control side, it would be good public policy to try to expand the number of anesthetists as a cost-cutting mechanism?

Ms. KELLY. I come from Kaiser which is the largest HMO in the country. They see the mixed practice of the nurse anesthetist and anesthesiologist as the way to provide good anesthesia service. Therefore, we have a ratio of probably 5 to 1, more or less, it is according to the kind of case. That does in fact cut the costs.

Mr. GRAMM. Thank you, and thank you, Mr. Chairman.

Mr. WAXMAN. I want to thank you for your testimony. It has been very helpful to us and I appreciate your coming from Los Angeles. I know what a long trip that is.

Ms. KELLY. Thank you very much.

Mr. WAXMAN. I would like to welcome Dr. Ralph H. Hines, provost and executive vice president of the Meharry Medical College, Nashville, Tenn.

STATEMENT OF RALPH H. HINES, M.D., PROVOST AND EXECUTIVE VICE PRESIDENT, MEHARRY MEDICAL CENTER, NASHVILLE, TENN., AND ON BEHALF OF XAVIER UNIVERSITY OF NEW ORLEANS AND SCHOOL OF VETERINARY MEDICINE, TUSKEGEE INSTITUTE, TUSKEGEE, ALA.

Dr. HINES. Thank you, Mr. Chairman, ladies and gentlemen of the committee.

I am Ralph H. Hines, provost and executive vice president of Meharry Medical College in Nashville, Tenn. I am pleased to testify at this time and to represent two additional institutions with their authorizations, Xavier University of New Orleans and the School of Veterinary Medicine at Tuskegee Institute, Tuskegee, Ala.

Each of us, as predominantly black institutions, share a common problem in varying degrees. I have reference to the need for Federal assistance in specific programs in our efforts to maintain quality training for nurses, physicians, dentists, veterinarians, and pharmacists.

The Congress has declared that the availability of high quality health care to all Americans is a national goal. The Congress has further found that the availability of high quality health care is to a substantial extent dependent upon the availability of qualified health professionals.

We therefore wholeheartedly support the Nurse Training Act proposal of H.R. 1143, particularly since this would affect the health care of minorities throughout this country.

The ability of our three institutions to provide health professions manpower is critical to meeting a national need. It is significant that Xavier University and Howard here in Washington, D.C. for example, provide 80 percent of the black pharmacists trained in the United States as a whole and that Tuskegee Institute provides 95 percent of those trained in veterinary medicine in the South and 90 percent of those trained in the country.

Meharry Medical College still retains an enviable record of having trained 43 percent of all living black physicians and dentists practicing in the United States. It is likewise important to

recognize that 38 percent of all entering students in the medical schools of the South and 49 percent of all black dental students are at Meharry in Nashville.

It is further noteworthy to point out that 76 percent of our graduates provide those basic human services needed in the delivery of primary care, particularly family medicine, the latter having been established by Congress as a objective.

We are greatly concerned with the cutbacks, recessions, and short funding that is being applied across the board, particularly since there is a declining number of minorities who are entering the health professions from peak entry points that were obtained through a variety of concerted resources being brought together in the early 1970's.

There are in fact fewer minorities entering the health professions today than there were 5 years ago.

It is unquestionably true that together—Tuskegee, Xavier, and Meharry Medical College—constitute national resources which cannot be duplicated in other institutional settings or combinations of institutions, yet each of us is struggling to survive under the mounting pressure of increased cost without concomitant assistance from local, State or Federal sources.

Most recently funds available for schools in dire financial assistance was dramatically cut. The pressure of reduced funding has in turn created a vacuum of financial hardships which none of us can fend off nor meet with certainty.

Indeed, the very mechanism which has propped to be of assistance to us has caused us to sink deeper into debt as the result of the mechanism which requires deficit spending before eligibility is recognized for participation in the program.

In addition, the present financial distress section of the Health Manpower Act places a limitation on participation in a manner which is calculated to eliminate the schools most in dire financial need. This is the so-called 75 percent rule which says in effect that a school can receive no more than 75 percent of what it had received the previous year.

We believe that in unusual circumstances, such as those facing minority institutions, this is an unrealistic and detrimental regulation. We would therefore propose that this rule be amended so that, at the discretion of the Secretary, he would be allowed the opportunity to waive this requirement for those schools who have unusual circumstances and are in dire need of financial assistance. This point is brought up in connection with the amendment to the proposed bill, H.R. 1143.

The Nursing Training Act under consideration by this Committee is an appropriate and necessary provision of law to enable more minority health workers to enter the health field and to provide services needed throughout the country in underserved areas.

Without the valuable assistance in which nurse training can provide, the delivery of health care becomes impaired and indeed reduced because of the maldistribution problems particularly affecting minority groups throughout the country.

The rural areas of the country and the inner cities suffer most from this maldistribution and institutions such as Xavier, Tuske-

gee, and Meharry are geared essentially to serving the needs of rural and urban populations in great need.

The enactment of the legislation being considered would enable us to gain a significant foothold in a difficult period as an interim step toward long-range solutions. These solutions, we believe, are required through thoughtful legislative programs.

The consideration of this committee regarding our concerns is greatly appreciated. I would be happy to answer any questions you may have.

Mr. WAXMAN. Thank you very much for your testimony, Dr. Hines.

If this 75-percent rule is not repealed, what will happen at your institution?

Dr. HINES. At our institution, the rule has a significant effect of cutting our ability of meeting financial needs for the current fiscal year that would amount to a little bit under \$1 million that we do not have available nor have any opportunity of seeing it forthcoming in any of the regular generated income sources to us.

It would have severe consequences for us during this present fiscal year. Our concern in that area, of course, is grave and this rule leaves in a hole or gap to sustain a quality educational program.

Mr. WAXMAN. The money that is proposed to be limited is termed a financial distress grant. What are the criteria of the Department which are used in deciding to give that grant?

Dr. HINES. The grant is competitive to all institutions. The basis and criteria used are those which relate to severe financial need that must be proven and those institutions that require financial assistance because of accreditation problems or difficulties.

The money that is being held at this time is available. HEW received an appropriation sufficient to fund 100 percent of the financial distress needs of all the applicants. Under the rule which is being proposed at this time, it is not disbursing those funds.

Mr. WAXMAN. Thank you. Mr. Preyer?

Mr. PREYER. Thank you, Dr. Hines, for your testimony.

You made an alarming statement that there are fewer minorities in the health delivery system today than there were 5 years ago. Is that correct?

Dr. HINES. That is correct.

Mr. PREYER. Does that count doctors, dentists, nurses?

Dr. HINES. That accounts for essentially physicians, dentists, and nurses entering the health professions as first year-students or as first-level trainees. This is particularly alarming since the administration is proposing in fact to do something which it has not succeeded in doing when it originally made the proposal to Congress to increase the number of minorities.

It is not proposing to do something to offset a decline in the number of minorities entering the health professions.

Mr. PREYER. How many doctors do you graduate at Meharry now for this year?

Dr. HINES. We graduate 124 physicians and 46 dentists. We have a nurse practitioner program with 75 enrollees at the present time. This is the largest group we have had of nurse practitioners. It has gone up from 50 to the present 75.

We represent one of the private, non-State supported independent institutions in the country that is trying to provide training opportunities and open access to minorities in the health professions.

Mr. PREYER. How do the 124 physicians and 46 dentists compare with 5 years ago or 10 years ago at Meharry?

Dr. HINES. Ten years ago, we were graduating approximately 65 physicians and 40 dentists. The level of increase in our dental enrollment has been not as great as in the medical school enrollment essentially we did not have facilities for dental increases that we presently have.

We are prepared to go to 100 dental students in the entering class and we will be doing so within the next couple of years, provided that we can find a sound basis for financing the institution.

Mr. PREYER. Meharry has certainly done a fine job. It has a very fine reputation. When you combine the factor of fewer minorities in the health delivery system than we had 5 years ago with the effect of the 75-percent figure in the health manpower bill, it seems to me it would certainly justify making an exception certainly for predominantly minority schools in that bill.

I thank you for your testimony.

Mr. WAXMAN. Ms. Mikulski?

Ms. MIKULSKI. Thank you, Mr. Chairman.

Doctor, when you talk about the less number of minorities and you outline doctors, veterinarians and nurses, what about allied health professionals? Do you also train those at Meharry?

Dr. HINES. Yes; we do. We do it either singly as an institution or in combination with a local State institution, Tennessee State University, which is near us.

Ms. MIKULSKI. Is that number on the rise or on the decline?

Dr. HINES. That number generally is on the rise but largely as a result of concerted effort on our part to see a larger number of students get into these fields and largely because of State participation in the funding of these programs.

Ms. MIKULSKI. The reason I asked that is it is within financial accomplishment, it is within the realm of personal accomplishment.

I taught at a community college in Baltimore. I did not always sit around reading the Federal Register. I remember many of my students either black or white knew this was the first step in terms of their family moving into a health care field. They knew they did not have the money to go to medical schools but they felt if they got in at this level, that is the way they could earn a good living in health care.

They could also afford the tuition and it was a compact period of time before they could work.

How much does it cost and how much does Meharry charge students to train them as both physicians and nurses?

Dr. HINES. It costs \$17,600 per year to train a physician or dentist. Our tuition is \$4,000 a year. The nurse practitioner training costs the institution \$9,000 a year and we charge a tuition of \$2,000.

Ms. MIKULSKI. Doctor, where do you make up that other money? Does that come out of the financial distress bucks?

Dr. HINES. A large portion has come from the financial distress grants which we have received in past years and which has been critical to our budget formation.

The rest has come from private solicitations, campaigns of fund raising, donations and gifts which is a constant involvement that a private institution has to be concerned with and deals with constantly in terms of making up that tremendous difference between the cost of education and the amount a student can afford to pay.

Ms. MIKULSKI. What you have indicated is your school and perhaps Howard and a few others play an unique role since your medical institution really serves the Nation as compared to a State medical institution that serves a particular geographic area. Your graduates go around the country but in effect your connection, financial connection with the Federal Government should be much stronger than those who receive State support.

Dr. HINES. We believe we should and we believe we are a national resource and that because of the unique character of the institution but and because we have no basic local or State base for which we can ask for assistance that our role in terms of federal assistance ought to be clear.

Ms. MIKULSKI. Even with such a low charge, Georgetown has just raised their medical school fees to \$13,000 a year and you charge \$4,000.

How many of your students can pay for the full charge?

Dr. HINES. About 12 percent; 88 percent of our students are scholarship or assisted students or students who acquire federally insured loans or participating in some sort of loan program.

Ms. MIKULSKI. You heard Dr. Foley talk about what a bang-up job they are doing over in the Office of Education in the field of making scholarships and other educational opportunities available. Has that been the experience of your students in terms of applying for this assistance or do you think we really do need targeted health financial assistance either in training, scholarships, loans; there is a range.

Dr. HINES. We have seen the erosion of Federal assistance in the student aid package for the last 5 years. The amount of money coming to the institution in direct grants has gone down significantly. Five years ago, our institution was receiving approximately \$700,000 a year for disadvantaged students, in financial assistance. We are now down to \$34,000 of grant money from the Federal program run by the Office of Education.

Likewise, the loan program has practically dwindled up in terms of direct loans to students and the federally insured loan programs which the Office of Education is responsible for administering now has come into more prominence.

We do not see that this has been a good working development in the way of administering aid and assistance to disadvantaged students or students who come from economically disadvantaged backgrounds.

I must confess that the Office of Education activities are new since the health professions loans and financial assistance to stu-

dents has been a separately administered program up until this year. We have no experience with the Office of Education per se.

Ms. MIKULSKI. Thank you, Dr. Hines. Thank you for sharing this information with us.

Mr. PREYER [presiding]. Mr. Gramm?

Mr. GRAMM. Thank you, Mr. Chairman.

Dr. Hines, I want to be sure I have the figures right. Are you saying that the number of blacks entering the health care professions has fallen over 5 years or the proportion it makes up of the number of entrances has fallen?

Is it an absolute decline or is it a percentage of the market decline?

Dr. HINES. It is both. Five years ago, there was 7.4 percent of all entering students in medical schools that were black students. This was short of the goal of 12 percent which was created in concert by the AAMC, the AMA, HEW and all of the schools of the country in an effort to increase minority participation.

That number is now 5.9 percent of those entering medical schools in the first-year classes which is a significant percentage decrease. When you look at the numbers that are involved, you can see a change there.

This is reflective of a lot of different factors but one of the problems as I see it is there has been a turnoff of encouragement for minority and other disadvantaged students to enter the health professions because of the drying up of support programs, recruitment retention programs, special projects to assist students who come from backgrounds of deficiencies, and scholarship aid.

That support has gone down and as a result we have seen a drop in the pool as well as in the number of blacks entering the health professions.

Mr. GRAMM. I would have to say that is an alarming fact and I think it would be of great surprise to the average person in the American citizenry. I think the average person on the street has an idea, at least in terms of lip service, our Government has instituted a drive to try to make it possible for more blacks to get into professions in general and the medical profession in particular.

What you are telling us here today is not only has the program not worked but in the last 5 years it has slid backward.

Let me ask you another question. What would you think of a program whereby you might establish the full cost of providing training for a position and the Federal Government, through a long-term loan program, might go out and borrow the money competitively on the market with Federal guarantees and the power of the Federal Government to borrow money and lend that to students with a long-term payback but at competitive rates?

Would you support such a system?

Dr. HINES. I would support the concept but the difficulties are enormous in terms of the actuality. In fact, this Office of Education program which Mr. Foley talked about earlier today does almost that inasmuch as the program allows a student to borrow up to \$10,000 a year.

The payback is a tremendous burden when one looks at financing \$50,000 worth of education over a 4-year period and repaying

approximately \$168,000 if one takes it to the 10-year payout period that is laid out.

It poses several different kinds of problems I think for a number of reasons. The whole question of contemplation of that kind of a payback, the interest rates in today's market are extremely high. They are real nonetheless. If a student is faced with that kind of alternative or nothing, then I am persuaded that they would consider that.

Among minority students, I think the idea of having that kind of indebtedness wrapped around one's head poses real serious problems.

I would prefer an alternative to that in which there would be either an approach in which that loan could be forgiven if that person does in fact commit himself to serving in an underserved area for a period of time following his graduation or internship or residency and that option would not simply be there as a carrot but as a way of providing the student with the opportunity of seeing that I have hope of moving on and doing some things without being straddled.

Mr. GRAMM. Let me tell you my concern that just came up because you are the first person in an administrative position in a medical school that has come before this committee since I have been on it.

I firmly believe that we need to train more medical personnel from LPN's to physicians. The question is how are we going to fund it in a way that is equitable to the American taxpayer because someone has to pay for it.

People in my district have no problem in providing funds for someone who is going to go into the marketplace and has an entry income level of \$10,000 to \$12,000, because they clearly recognize the need.

Where I run into problems, is where the average blue-collar worker in my district says, look, I am paying taxes and I am subsidizing a fellow to go to medical school. I know we need doctors, I wait in line hours and hours to see one. But I am funding his way through medical school by paying taxes. When he gets out of school, he is going into the labor market making what to me is a fantastic salary.

The question that seems to be in the minds of the taxpayer and I feel it should therefore be in the minds of the Congress, is a simple question and that is, I want people to go to medical school and I want qualified people to be admitted and trained and allowed to enter the marketplace. The question is. How are we going to pay for it?

It seems to me that I would be willing to support a program which provided federally guaranteed loans across the board. The question is how far can we go by simply providing grant and aid?

You have a person in a position who is uniquely qualified to pay the taxpayer back. You have a person that is going to become a leader in his community. He is going to become wealthy by the conceptions of the average blue collar worker.

I think it is a legitimate question as to whether the taxpayer should provide the degree of subsidy.

I think our problem in an era of economy in Government, when the administration, a Democratic administration, is calling for cutbacks in programs that we have viewed as humanitarian programs that have always been the core of the platform we have offered to the people, and in an era where we have stated goals, for example, of producing more minority positions and nurses and paramedical personnel.

It seems to me that what we need is a vehicle for funding which can be sold to the taxpayer. I think it is very important that we try to come up with a package that at least in the physician area, gives the taxpayer some assurances that we can recoup some of the costs from the person who goes on and makes \$80,000 or \$90,000 a year.

Dr. HINES. I do not argue with the concept, Congressman. I basically agree with the concept and the rationale behind doing it that way, it is quite sound.

The only thing I am suggesting is in the case of minority students, I think you have to look at the issue a little differently. I think there is a necessity for a combination of grant and aid as well as loans.

The minority physician is not going to reap the benefits of the majority community, the marketplace, in the same degree and terms. Be that as it may, he nonetheless is going to commit himself to a service which is, from the taxpayer's point of view, the redemption of those years of training and so on when he says, I will go and work in one of these places where it is undesirable from a lot of point of views.

Our graduates do go back into rural and urban inner city areas where it is not the most desirable area to work from a lot of points of view, professional and otherwise.

My only concern would be while this approach from the point of view of physicians across the board may be very sound and basic and important from the taxpayer's point of view, I would only hope there be some consideration drawn to the question of what kinds of alternatives do we have for those who are willing to work in areas of great dire social need where they would not otherwise have the services of a physician or dentist and who are deserving as taxpayers and citizens of this country to have the accessibility to a physician.

Mr. GRAMM. I think your suggestion is a good one. I know I would have no trouble supporting a bill that really did two things in addition to the loan program; one, credits on loan payback year by year but not on promises, for a person who practiced in inner cities.

I think also the person receiving the loan and the training could be given some assurances that the payback would be based on gross income, rather than on a general basis and that income could be targeted toward the mean income for physicians.

Dr. HINES. About 88 percent of them.

Mr. CARTER. The \$12,000 you mentioned which does not account for books, board, and all that goes with it, is a pretty significant financial burden.

Do you have very many scholarships or not?

Dr. HINES. As an institution control or own, yes, sir.

Mr. CARTER. For some of your students who would otherwise have great difficulty.

Dr. HINES. We have a limited private scholarship program.

Mr. CARTER. No federally funded scholarships?

Dr. HINES. The federally funded scholarship program has been practically reduced to zero.

Mr. CARTER. This would have a great adverse affect upon your institution, is that correct?

Dr. HINES. That is absolutely correct.

Mr. CARTER. It would have the same impact on many of the other institutions throughout our country as I see it, particularly, some of the ones that do not have an abundance of funding from wealthy State treasuries.

I certainly am glad to see you here and I am proud of your institution.

Dr. HINES. Thank you. I appreciate this opportunity to appear before this committee. I thank you very much also.

Mr. PREYER. You have given us some very interesting facts and figures and ammunition. We appreciate your being here.

The committee stands adjourned.

[The following statements and letters were received for the record:]

AMERICAN ASSOCIATION OF COLLEGES OF NURSING

by

Linda K. Amos, R.N., Ed.D.
Dean, Boston University School of Nursing

On behalf of the American Association of Colleges of Nursing I urge prompt enactment of H.R.1143, the Nurse Training Act, to provide a continued program of support for nursing. We urge full support and quick passage of H.R.1143 in order to assure stability in the planning and management of critically needed nursing programs throughout the country. The future health of our country is dependent in large part on the continued federal support of nursing programs. Nursing represents the largest aggregate and most consistent provider of health services. Nurses are providing primary health care to many sectors of our society and have been responsive to the changing demands in the health care arena. It is important to assure that a sufficient number of nurses with adequate preparation will be available to serve the nation's health care needs over the next several years. Enactment of the Nurse Training Act, as proposed in H.R.1143, will provide support to necessary programs while a major study to be conducted by the National Academy of Sciences will determine the need to continue specific programs of federal support for nursing. Results of this study, along with other studies and data on major health problems and delivery systems, will provide the basis for the formulation of a revised proposal for federal support of nursing for the future.

The urgent need for continued support of all programs contained in H.R.1143 with a priority emphasis on graduate training in nursing, is clearly evident from the data recently obtained in a study conducted by the American Association of Colleges of Nursing on the needs and resources of schools of nursing. Forty-eight percent (48%) of the schools surveyed indicated that curtailment or loss of federal funding would necessitate elimination of one program category. Approximately three quarters or seventy-three percent (73%) of the schools indicated that a loss of federal support would necessitate a significant lowering

of enrollment in one or more of the baccalaureate or higher degree programs. Creation of such a situation would be highly counterproductive in our attempts to provide more equitable access to a higher quality of health care. In order to assure adequate numbers of qualified professional nurses, many more graduates are required from baccalaureate and graduate programs.

It is clearly evident at this time that we have acute shortages of nurses prepared to function for beginning, primary and specialized roles in every geographic area of this country. In a recent study conducted by the Western Interstate Commission for Higher Education, and supported by the Division of Nursing, Bureau of Health Manpower, entitled - Analysis and Planning for Improved Distribution of Nursing Personnel and Services, the final report of the panel of experts projects a continued shortage of nurses for many years to come. The report states, "With consideration of population growth between 1976 and 1982 of 6 percent, and within the context of the current and prospective health care scene, the panel projected a need for 1,219,300 to 1,677,000 full-time equivalent (FTE) registered nurses necessary to meet the nation's needs in 1982. This projection is an increase of 48 to 104 percent above 1976 levels." These projections are based on state and national planning models which take into consideration the increasing complexity of health care, the substantial change in the scope of nursing practice, and the federally defined health goals as contained in the Health Planning and Resources Development Act of 1974. "...These projections are the Panel's appraisal of what is required to provide the quality of nursing services needed to provide care acceptable and accessible to nearly all the nation, with consideration of cost containment."

At the present time, approximately 20% of the total registered nurse population has earned a baccalaureate or higher degree in nursing. With the Panel's projections of a required 64 to 66 percent of registered nurses to be prepared at the baccalaureate or higher degree level, we clearly can not approximate our needs without continued support and increased support for baccalaureate and graduate preparation in nursing.

Baccalaureate graduates are prepared as primary health care providers and provide emphasis on prevention, health teaching, education for self-care and maintenance of good health in acute or ambulatory settings. They are the beginning practitioners in primary, secondary and tertiary health systems and as such should constitute the bulk of practicing nurses for the future if both care goals are to be achieved. Graduates of master's programs are prepared as advanced practitioners in primary care, clinical specialists, managers of nursing care, nurse educators, and researchers.

Data from the American Association of Colleges of Nursing study indicate that institutional support for baccalaureate programs in the form of capitation is needed to support the salaries for faculty positions, faculty development, instructional media material and some of the operational expense of the school. In selecting program options as a basis for eligibility for capitation programs, twenty-five percent (25%) of the schools indicated that they were conducting programs for recruitment of students from disadvantaged backgrounds; twenty-seven percent (27%) were providing a significant portion of clinical experiences in geographically remote areas; and forty-four percent (44%) were providing continuing education programs for nurses based on assessment of local and regional needs. Such important programs can only be continued with capitation funds and these programs are responsive to the pressing and critical health problems of our times.

In order to assure a steady supply of qualified nurses, student support in the form of scholarships, loans and traineeships are required. Data from the American Association of Colleges of Nursing Study indicate that an additional 1,980 master and 165 doctoral students could pursue full-time versus part-time study, if additional student support were available. An adequate base of student financial assistance would allow us to respond more quickly to the critical need for nurses prepared at the graduate level. Rising tuition levels in both the public and private sectors have resulted in a reduced number of students being supported by traineeships.

The Advanced Nurse Training funds are the only source of basic support to graduate programs. The need for more nurses with advanced preparation to work as practitioners, clinical specialists, educators, administrators and researchers is critical. It is not expected that the need can be met for many years to come if current funding levels are maintained. The American Association of Colleges of Nursing study indicates that during the 1977-1978 academic year there were 381 budgeted, unfilled faculty positions requiring minimal preparation at the master's level, and another 513 budgeted, unfilled positions for faculty prepared at the doctoral level. Projection of additional needs for the year 1980 triples for master's prepared nurses and more than doubles for doctorally prepared nurses in educational settings alone. It is estimated that the need for nurses with advanced degrees in service settings is just as critical.

Special projects support has been of tremendous assistance to schools of nursing by fostering creativity and innovation in education, including basic, advanced and continuing education. Support for special projects is necessary in order to continue the emphasis on newer

approaches in nursing education which help establish community demonstration projects, interdisciplinary programs, and promote more effective utilization of resources.

In summary, the American Association of Colleges of Nursing urges your support of H.R.1143 as it does continue a sound program enabling schools of nursing to prepare the kinds of practitioners needed to meet national health needs. Through this program, the profession's capacity to respond to health care demands, especially the demand for primary care can be increased; and, it will assist in assuring a supply of nurses for health care delivery with advanced scholarly training for practice, teaching and research. Without stable Federal programs and adequate levels of appropriations to implement these programs, we will witness a shortage of qualified manpower to provide the health services required for the present and future and see inefficiency in the management of nursing education programs.

The President's veto of the Nurse Training Act last November was a shock to nursing consumers and other health professions. It was followed by an even greater shock when the President's request for rescission totaling \$84 million came after we had been assured that there would be no abrupt termination of nursing programs. Documented evidence fully justifies the need for federal support to nursing, and the quick enactment of H.R.1143 will assist in providing stable, effective and quality programs in nursing which meet the manpower needs of our health care system.

LKA:smc
March 19, 1979

STATEMENT OF NATIONAL STUDENT NURSES' ASSOCIATION, INC.

Mr. Chairman and Members of the Committee:

The National Student Nurses' Association is pleased to have the opportunity to submit this testimony to the House Interstate and Foreign Commerce Committee, Sub-Committee on Health.

This statement is presented on behalf of the National Student Nurses' Association, an organization with a membership of approximately 33,000 undergraduate nursing students from across the country. Our association is composed of students in associate degree, diploma and baccalaureate schools of nursing.

We strongly support an extension of the Nurse Training Act. This legislation provides vital assistance that enables many undergraduate nursing students to complete their education who otherwise would be unable to. In addition, many graduates of associate degree and diploma nursing programs are returning to school to receive the bachelor of science degree in nursing and go on for graduate education. This group of students represents a potentially large group of nurses who could be prepared for advanced and specialized nursing practice and practitioner roles. However, they must first complete their undergraduate education, an expensive and time consuming process.

Undergraduate nursing education has continually increased in quality and sophistication over the years, which has made it a more expensive endeavor for both schools and students.

Tuition in private and public schools alike has risen sharply. In addition to tuition costs, books and supplies, nursing students face an added financial burden for uniforms and transportation to and from clinical experiences.

Nursing students have less opportunities to earn the needed funds since they often have less time to work. Clinical experiences often average 20 hours a week, in addition to classroom instruction and study time. The National Student Nurses' Association did a survey of our memberships' financial aid needs in 1978. The survey returns indicated that sixty-five percent of the respondents worked to meet the cost of their education. Fifty-one percent of the respondents indicated that they received federal financial assistance for their nursing education. Eighty-one percent of these students stated that they could not have attended school without this assistance. Fifty-one percent total respondents came from families with incomes below \$15,000 per year.

NSNA offered a small scholarship program to its membership this year. This program had only 12 scholarships available, and was only publicized within the organization. Over 600 qualified applications were received for the 12 awards, all of whom demonstrated financial need.

Although undergraduate nursing students do have other financial aid resources, both on the federal and state levels, the federal nursing student assistance is the primary source

of funds. To receive general educational support, such as the Basic Educational Opportunity Grant Program, the nursing student must compete against a huge pool of other applicants from all disciplines. The National Health Service Corps scholarships have been opened to nursing students, but on an extremely limited basis. Currently, 90 percent of these scholarships go to medical students, and 10 percent to the remaining health disciplines. Only baccalaureate nursing students are eligible to apply.

Two areas in the Nurse Training Act are of specific concern to NSNA and to nursing students. These are nurse training loans and nurse training scholarships. We strongly urge their continued inclusion in an extension of the Nurse Training Act.

NURSE TRAINING SCHOLARSHIPS

The Nurse Training Act of 1975 provided for scholarships to be awarded to those of "exceptional financial need who need such financial assistance to pursue a course of study at the school for such year." Presently, there are 564 undergraduate nursing schools participating in the scholarship program.

Scholarships are of particular importance to nursing students from disadvantaged and low-income backgrounds. Many times federal scholarship monies are the only thing which make it

possible for these students to complete their nursing education. Nursing has been successful in attracting members of minority groups into the profession, and the availability of Nurse Training scholarships has been most helpful in this.

NURSE TRAINING LOANS

The Nurse Training Act of 1975 authorized a program of low-cost loans for full and part-time students. Presently, 448 undergraduate schools of nursing participate in the nursing student loan program.

The nursing student loan program has been quite successful and has given many students the chance to complete their nursing education. The default rate for paying back nursing student loans has been quite low.

Loans have become a major source of financial aid for many undergraduate nursing students. Many have begun or continued their education with the understanding that loan money will be available. NSNA strongly believes that the nursing student loan program is necessary and should be continued. As it is, many students must seek other financial aid sources in addition to Nurse Training Loans to cover the cost of their nursing education.

The importance of nursing in the American health care delivery system has long been recognized by Congress. With its increasing educational sophistication and expanding scope of practice, nursing can help to offer many solutions to the health care delivery problems in the United States.

We urge you to approve an extension of the Nurse Training Act. We would like to thank the committee for giving us this opportunity to share our concerns with you.



AMERICAN HOSPITAL ASSOCIATION
 444 NORTH CAPITOL STREET, N.W. SUITE 500 WASHINGTON, D.C. 20001 TELEPHONE 202-638-1100
 WASHINGTON OFFICE

**STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION
 TO THE
 SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
 OF THE
 INTERSTATE AND FOREIGN COMMERCE COMMITTEE
 ON BILLS TO EXTEND THE NURSE TRAINING ACT**

March 28, 1979

The American Hospital Association represents more than 6,400 member institutions, including most of the hospitals in the country, and over 2,300 nursing service administrators among our 27,000 personal members. AHA member hospitals operate 367 schools of nursing with an enrollment of 56,000 students. We welcome the opportunity to present comments on two proposed bills to extend the Nurse Training Act, H.R.1143 and H.R.1651, and to reaffirm our strong support for the extension of this Act.

H.R.1143, introduced by Rep. Harley Staggers (D-W.Va.), Chairman of the Interstate and Foreign Commerce Committee, proposes to extend the 1975 Nurse Training Act through FY 1980 at a total authorization level of \$209 million. H.R.1651, introduced by Rep. Tim Lee Carter (R-Ky.), ranking minority member of this Subcommittee, would extend the provisions of the Nurse Training Act for FY 1980 and FY 1981 at a \$182 million authorization level for each year.

The AHA's concern with the educational preparation of nurses stems both from the role of many hospitals in providing clinical training for nurses and from hospital sponsorship of schools of nursing. Each year the hospital schools of nursing produce 25 percent of the new graduates entering professional nursing and in some areas of the country these diploma schools provide the only source of new nurses. In addition, hospitals are the nation's

largest employer of registered nurses. It is therefore extremely important to hospitals that nursing students receive high quality, appropriate education. Their educational experience should prepare them to function effectively in their profession upon graduation, and also should encourage them to pursue further education to develop additional professional skills.

We would like to offer the following comments and recommendations on the specific provisions of these bills.

Capitation Grants

The AHA supports the continuation of capitation grants for all three types of basic nursing programs: diploma, baccalaureate, and associate degree. Nursing schools are dependent on capitation funds for general support and for the enlargement of faculties. Without such funds, the current serious shortage of nursing school faculty would be aggravated, resulting in cutbacks in educational programs. These cutbacks, in turn, would result in a decreased supply of nurses, at a time when there is growing evidence of a shortage of nurses.

The AHA, in cooperation with a number of state and metropolitan hospital associations, recently conducted a survey that revealed a continuing shortage in the number of registered nurses in many areas of the country. Hospital associations in 33 states reported a shortage of registered nurses available for employment in hospitals. For example, in California, 17 percent of the budgeted registered nurse positions in hospitals are unfilled. In the greater Milwaukee area, the reported shortage is 12 percent; in western Tennessee, the shortage is 33 percent; in Arizona, 21 percent; and in Texas, 14 percent. In addition, the Illinois Hospital Association reports a shortage of 3,500 nurses in that state. The shortage of nurses to fill available positions is particularly acute in inner cities and in rural areas. Further, the shortages are more severe for the less desirable night shifts, mundane services, and hospitals located in insecure neighborhoods, but shortages are not limited to these circumstances.

In addition to these nursing shortages in hospitals, Department of HEW statistics predict a need for over 30,000 additional registered nurses in nursing homes by 1985 to maintain even the present staffing levels. It is important to note that currently only one in ten of the total nursing home work force is in the professional or technical category. To improve the quality of care in nursing homes, significantly greater numbers of professional nurses would be required.

The funds authorized in both H.R.1143 and H.R.1651 for capitation programs would help alleviate these shortages, provide important support for faculties and maintain the financial viability of many nursing education programs.

Special Projects

Special project grants have been provided in the past to encourage mergers and cooperative arrangements between institutions of higher learning and hospital schools of nursing. Mergers are particularly cost effective in that they maximize the use of resources and create desirable linkages between the academic environment and the clinical setting. In this context it is especially encouraging to note the contribution which such joint ventures can make to the hitherto successful cost containment program of the health care industry—the Voluntary Effort.

Special project grants have also been used to fund the development of new curriculum initiatives. The modification of existing programs is of special importance in the upgrading of nurses from diploma or associate degree programs to baccalaureate degree curricula. Presently, there are waiting lists for such programs in many baccalaureate schools, and the potential number of such students is great.

Greater use of special project grants should be devoted to important continuing education programs and retraining programs for nurses who are reentering the field after having been out of the work force for a time. Such programs are increasingly needed to enable nurses to keep up with the fast moving technologies found in the health care field. Retraining

programs make possible optimal use of a potential labor pool, a reservoir of capital investment in human resources which should be retained.

Finally, special project grants continue to provide the stimulus for much of the innovation in nursing education programs today. For these reasons, we support the continued authorization for special project grants.

Advanced Nurse Training

Funds for advanced nurse training programs provide support for three important purposes: further educational preparation to better qualify faculty members to teach nursing, managerial education for supervisory and administrative nurses, and advanced training in specialty areas, such as gerontology, and maternal and child health care. Programs for all three of these purposes have a direct correlation to improved care to patients, since advanced education for a cadre of professional leaders has a highly desirable ripple effect throughout the profession. Higher quality patient care is promoted by better educated nurses who serve as role models; and by teachers and researchers whose influence upgrades the hospital staff as a whole.

The training of nursing faculty is critically important. Unfortunately, at present, there is a shortage of nursing school faculty. According to a National League of Nursing survey, over 800 teaching vacancies presently exist. There is also a lack of faculty with graduate degrees; according to the same survey, only 44 percent of all current nursing faculty have master's degrees or above.

Another area of special concern to the AHA is the lack of management education for nursing personnel. Nursing service administrators are not infrequently responsible for 40-60 percent of hospital human resources budgets, frequently with little or no management education other than on-the-job training.

Advanced training for nurses is also needed in clinical specialties, such as maternal and child health care, community nursing and gerontology--areas which have been identified by the Administration. The need for advanced training also exists in hospital nursing where the establishment of critical care units has necessitated a higher level of sophistication; nursing personnel in these units must exercise skill and judgement at a more advanced level than has been traditionally associated with professional nursing. Also, a more highly trained staff is needed to evaluate and implement the clinical nursing research presently being carried out. We support continued funding for these advanced nurse training programs.

Nurse Practitioners

The nurse practitioner program is a means of addressing the need for primary care practitioners especially acute in medically underserved areas. Nurse practitioners have the potential to (1) render cost-effective primary care, (2) offer disease prevention and health promotion services, (3) provide primary care services as authorized under P.L.95-210, the Rural Health Clinics Act, (4) act as primary health care practitioners in underserved urban areas, (5) render specialized nursing services such as routine obstetrical, gynecological, and pediatric care, and (6) carry out large-scale public health projects (such as those undertaken through school nurse programs). Because of this program's potential in extending the delivery of certain health services, AHA supports continued federal assistance for the development of nurse practitioners.

Assistance to Nursing Students

Special consideration is needed for students in basic nursing education programs, certainly as much as it is needed for institutional support. Without a continuation of the federal nursing student loans and scholarships authorized by these bills, many deserving applicants will not be able to prepare for a career in nursing. Over 50 percent of respondents in a recent National Student Nurses Association survey had received federal support; of these, many were dependent on such support to the extent that they could not continue their education without it.

We do not believe, as the Administration maintains, that reliance on funds from Basic Education Opportunities Grants and Supplemental Educational Opportunity Grants, will be sufficient to meet the needs of individuals seeking to prepare for careers in nursing. AHA supports the proposed authorizations for loans and scholarships in H.R.1143 and H.R.1645.

In conclusion, the AHA believes that there is continued need for federal financial support of nurse training programs to assure quality delivery of health care both in the hospital setting and beyond. Thus, we strongly support the extension of authority for programs under the Nurse Training Act.

American Psychiatric Association

1700 Eighteenth Street, N.W., Washington, D.C. 20009 • Telephone: (202) 797-4900

March 15, 1979

The Honorable
Henry Waxman
Chairman
Subcommittee on Health and the Environment
2415 Rayburn House Office Building
Washington, D. C. 20515

Dear Mr. Chairman:

On behalf of the American Psychiatric Association, a medical specialty society representing over 24,000 psychiatrists nationwide, I wish to express our continued strong support for Section 202 of the "Nurse Training Amendments of 1979" (HR. 1651) and all other related pending nurse training legislation containing an identical provision. We believe it is critical to expand the availability of National Health Service Corps (NHSC) scholarships to individuals whose residency training extends beyond the three year deferral period presently authorized and appreciate and commend such amendment.

To buttress, support and provide further rationale for the intent of Section 202 to provide the Secretary of Health, Education, and Welfare the flexibility to extend the three year residency deferral, we would appreciate your favorable consideration of an amendment, hereinafter set forth, which would designate psychiatry as a medical shortage specialty.

As you know one of the President's Commission on Mental Health major recommendations was:

"The Health Professions Educational Assistance Act be amended to designate psychiatry as a medical shortage specialty and require medical schools to set aside a certain proportion of their residency positions for this discipline."

Section 202 alleviates existing law's clear disincentive to medical students with an interest in psychiatry since as the Subcommittee knows psychiatric residencies require four or five years of training. Also, presently a student interested in psychiatry either cannot take advantage of the program in the first instance, or alternatively enters the program and fulfills the payback provision inadequately and incompletely trained especially in the subspecialties of child and geriatric psychiatry.

Such restrictions upon the utilization of the NHSC by prospective psychiatric residents are particularly damaging in view of the serious shortage in manpower confronting psychiatry as a discipline.

As the President's Commission on Mental Health pointed out, the shortage of psychiatrists is attributable to several factors, to wit:

"In recent years, there has been a reduction in the numbers of American medical graduates entering psychiatric residency training. A severe restriction has also been placed on the entrance into the country of foreign medical graduates, many of whom enter psychiatric residency training and practice in State hospitals. Over half the psychiatrists and other physicians staffing these facilities are graduates of foreign medical schools."

We understand that the 50 percent figure cited above ranges as high as 90 percent in some states. Moreover, the proportion and number of American medical graduates entering psychiatry training dropped from 12 percent in 1970 to 6 percent in 1976, and in that latter year, 39 percent of all residencies in psychiatry were filled by foreign medical graduates (FMGs).

With the loss of the FMGs as the result of PL 94-484, coupled with the declining numbers of medical school graduates entering the field of psychiatry, the discipline is now suffering and will continue to suffer a severe shortage. Recent National Institute of Mental Health (NIMH) figures indicate there is a need for over 2,500 psychiatrists in State and county facilities alone; that two-thirds of all counties in the United States have no psychiatrists. Moreover, there is evidence from NIMH and HEW that psychiatrists are in short supply not only in critical State and county facilities, but by 1981 there will be an overall shortfall of psychiatrists of at least 10,000.

Moreover, if Congress approves the Administration contemplated Community Mental Health Systems Act, which would stimulate initiatives to provide services to the 20-32 million Americans identified by the President's Commission on Mental Health as in need of mental health care, including those in what currently are psychiatric manpower shortage areas, the need for adequately trained psychiatrists will further expand.

Accordingly, we recommend that Section 202 of H.R. 1651 be amended as follows using such as a model for the reported bill:

On page 9, between lines 19 and 20 insert the following:

(b) Section 2(a)(4) of the Health Professions Educational Assistance Act of 1976 (relating to Findings and Declarations of Policy) is amended by inserting before "physician" the following: "except for psychiatry which is a medical shortage specialty".

We understand that the Health Resources Administration has already suggested reserving 10-15 percent of its medical student scholarships in the NHSC program for those interested in specializing in psychiatry. Yet no efforts to date have been made to designate psychiatry a medical specialty shortage. The proposed amendment would be an important Congressional commitment to that goal and the need for amending the NHSC scholarship deferral eligibility.

We believe the amendment we propose, in combination with the bill's broadening of the service corps deferment for payback, will provide the foundation for a renewed and revitalized and adequately trained psychiatric manpower pool. It will not only help diminish the manpower shortage in underserved geographic areas of the country, but will provide the leadership and direction to any new mental health system established by Congress in the future.

We hope you will make this communication part of the hearing record and look forward to working with you.

Respectfully,

Jules H. Masserman, M.D.
Jules H. Masserman, M.D.
President

JHM:JBC:TF:mag



AMERICAN MEDICAL ASSOCIATION

535 NORTH DEARBORN STREET • CHICAGO, ILLINOIS 60610 • PHONE (312) 751-6000 • TWX 910-221-0300

JAMES H. SAMMONS, M.D.
 EXECUTIVE VICE PRESIDENT
 (312) 527-0001

March 29, 1979

The Honorable Henry A. Waxman
 Chairman
 Subcommittee on Health & Environment
 Committee on Interstate & Foreign Commerce
 United States House of Representatives
 Washington, D.C. 20515

Dear Congressman Waxman:

The American Medical Association submits the following comments on HR 1143, the Nurse Training Amendments of 1979. This bill would extend for two years the program of federal assistance for nursing education.

The AMA recognizes the important role of nurses in the delivery of health services. An adequate supply of properly trained nursing personnel is essential to maintaining the continuity and effectiveness of patient care. We believe that the federal government has played an important role in the support of nursing training and we recommend that support be continued.

The primary need now is to ensure adequate financial support for students and to continue assistance to existing facilities so they can maintain their educational programs. In view of the current budgetary restraints, such an approach is particularly desirable.

Therefore, we support an extension of the authorization of appropriations for the following nurse training programs: capitation grants to schools of nursing, special project grants and contracts, advanced nurse training programs, traineeships for advanced training of professional nurses, student loans, and scholarship grants.

We request that this letter be made part of the Subcommittee's official hearings record on HR 1143.

Sincerely,

James H. Sammons, M.D.

[Whereupon, the subcommittee adjourned at 1:10 p.m.]